Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA EX REL. JOHN C. KARVELAS, PETITIONER

v.

MELROSE-WAKEFIELD HOSPITAL; MELROSE-WAKEFIELD HEALTHCARE CORPORATION; HALLMARK HEALTH SYSTEM, INC.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does the heightened standard of pleading for "averments of fraud" apply to claims for recovery under sections 3729(a)(1) and 3729(a)(2) of the False Claims Act, that is, for claims that do not require proof of fraud as an element of recovery?

PARTIES TO THE PROCEEDING

The parties to this proceeding are the plaintiff, the United States of America, and its relator, John C. Karvelas, and the defendents, Melrose-Wakefield Hospital; Melrose-Wakefield Healthcare Corporation; Hallmark Health System, Inc.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

PARTIES TO THE PROCEEDING ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES iv

OPINIONS BELOW 1

JURISDICTION 1

RELEVANT PROVISIONS 1

STATEMENT OF THE CASE 2

STATEMENT OF FACTS 3

SUMMARY OF ARGUMENT 9

REASONS FOR GRANTING THE WRIT 11

CONCLUSION 29

APPENDIX

CIRCUIT COURT DECISION 1a

DISTRICT COURT DECISION 47a

ORDER DENYING REHEARING 82a

ORIGINAL COMPLAINT 84a

RELEVANT DOCKET ENTRIES 219a

31 U.S.C. § 3729. FALSE CAIMS 221a

RULE 9. PLEADING SPECIAL MATTERS 223a

SENATE REPORT NO. 99-345 ..... 224a

132 CONG. REC. S11243 (AUG. 11, 1986) (STATEMENT BY SEN. GRASSLEY) 262a

132 CONG. REC. H6478-6479 (SEPT. 9, 1986) (STATEMENT BY REP. GLICKMAN) 273a

132 CONG. REC. H6480 (SEPT. 9, 1986) (STATEMENT BY REP. FISH) 278a

TABLE OF AUTHORITIES

Page

CASES

BATES v. UNITED STATES, 522 U.S. 23 (1997) 18

HAGENY v. UNITED STATES, 570 F.2D 924, 933 (CT. CL. 1978) 15

LEATHERMAN v. TARRANT COUNTY NARCOTICS UNIT, 507 U.S. 163, 168 (1993) 3

MANCHEL v. KASDAN, 286 APP. DIV. 483, 144 N.Y.S.2D 694 (1ST DEP'T 1955) 15

SWIERKIEWICZ v. SOREMA N.A., 534 U.S. 506 (2002) ..... *passim*

UNITED STATES EX REL. BRENSILBER v. BAUSCH & LOMB OPTICAL CO., 131 F.2D 545 (2D CIR. 1942), AFF'D, 320 U.S. 711 (1943) 13, 26, 27

UNITED STATES EX REL. JOHNSON v. SHELL OIL CO., 183 F.R.D. 204, 208 N.6 (E.D. TEX. 1998) 22

UNITED STATES EX REL. KARVELAS v. MELROSE WAKEFIELD HOSPITAL, 2003 WL 21228801 (D. MASS. 2003) 1

UNITED STATES EX REL. KARVELAS V. MELROSE WAKEFIELD HOSPITAL, 360 F.3D 220 (1ST CIR. 2004) 1

UNITED STATES V. AERODEX, INC., 469 F.2D 1003 (5TH CIR. 1972) 13, 26

UNITED STATES V. FOSTER WHEELER CORP., 447 F.2D 100, 101 (2D CIR. 1971) 15

UNITED STATES V. MEAD, 426 F.2D 118 (9TH CIR., 1970) 13, 26

UNITED STATES V. MILTON, 602 F.2D 231, 233 (9TH CIR. 1979) 15

UNITED STATES V. UEBER, 299 F.2D 310 (6TH CIR. 1962) 13, 15, 28

STATUTES

28 U.S.C. § 1254(1) 1

31 U.S.C. § 3729 ..... 3, 4

31 U.S.C. § 3729(a)(1) ..... *passim*

31 U.S.C. § 3729(a)(2) ..... *passim*

31 U.S.C. § 3729(b) ..... *passim*

31 U.S.C. § 3730 ..... 9, 11, 12

31 U.S.C. § 3731(c) 28

OTHER AUTHORITIES

42 C.F.R. § 413.24 5

GREGORY G. BOOKES, THE FALSE CLAIMS ACT: CONGRESS GIVETH AND THE COURTS TAKETH AWAY, 25 HAMLINE L. REV. 373, 399-400 (2002) 25

OPINIONS BELOW

This petition seeks review of the First Circuit's opinion reported as *United States ex rel. Karvelas v. Melrose Wakefield Hospital*, 360 F.3d 220 (1st Cir. 2004). The district court's opinion is unreported but may be found at *United States ex rel. Karvelas v. Melrose Wakefield Hospital*, 2003 WL 21228801 (D. Mass. 2003).

JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1).

RELEVANT PROVISIONS

This petition involves the analysis and construction of two sources of statutory authority: (1) the False Claims Act, and (2) Rule 9(b) of the Federal Rules of Civil Procedure.

(1) The False Claims Act: 31 U.S.C. §§ 3729(a)(1), (a)(2), (b).

31 U.S.C. §§ 3729(a)(1) and (a)(2) create False Claims Act causes of action for "knowingly" presenting a false claim to the Government for payment or approval; or for "knowingly" using a false record to get a false claim paid or approved.

The False Claims Act also includes a definition of the terms "knowing" and "knowingly," 31 U.S.C. § 3729(b), and this definition makes it clear that fraud is not an element of these False Claims Act causes of action.

(2) The Federal Rules of Civil Procedure: Rule 9(b).

This petition also involves Rule 9(b) of the Federal Rules of Civil Procedure.

Rule 9(b) specifies that, for "averments of fraud," the "circumstances constituting fraud must be pleaded "with particularity."

Rule 9(b) also provides that "knowledge" and "other condition of mind" may be "averred generally."

STATEMENT OF THE CASE

This lawsuit, brought under the False Claims Act, 31 U.S.C. §§ 3729-3731, does not require a showing of all the fraud requirements. Counts I and II of the Complaint, brought on behalf of the United States of America through its relator, John C. Karvelas, assert that the defendants "knowingly" submitted false claims to the United States Government and that they "knowingly" used false reports to obtain Medicare and Medicaid reimbursements, in violation of 31 U.S.C. § 3729(a)(1) and § 3729(a)(2).

In the district court the defendants argued that these claims were "averments of fraud," and therefore subject to special heightened pleading requirements of Rule 9(b). Accordingly the defendants moved to dismiss the Complaint for failing to plead the circumstances of fraud "with particularity."

Over the plaintiffs' objection, the district court granted the motion and dismissed the entire lawsuit on the merits. On appeal, the First Circuit held that the heightened pleading requirements of Rule 9(b) applied to claims under 31 U.S.C. § 3729(a)(1) and § 3729(a)(2), thus affirming the district court's dismissal.

This holding is erroneous because:

(1) It runs contrary to the intent of Congress and the legislative purpose and intent of the 1986 Amendments to the False Claims Act, leading to the anomalous and irrational result that the standard required for pleading exceeds the standard required for proof at trial;

(2) It contradicts the principles set forth by this Court in *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506 (2002),and *Leatherman v. Tarrant County Narcotics Unit*, 507 U.S. 163, 168 (1993) and violates the very language of Rule 9(b) and the express terms of 31 U.S.C. § 3729.

STATEMENT OF FACTS

The claims asserted in the Complaint do not have to charge fraud. Instead they must charge that the defendants "knowingly" presented or used false claims. In the First Count, the plaintiff alleges the defendants knowingly presented or caused to be presented false claims for payment or approval to the United States. 31 U.S.C. § 3729(a)(1). (Complaint ¶¶ 449-451, 489). In the Second Count, the plaintiff alleges the defendants knowingly made, used, or caused to be made or used, false records or false statements to get false claims for paid or approved. 31 U.S.C. § 3729(a)(2). (Complaint ¶¶ 452, 454.)

John C. Karvelas was a respiratory therapist for fifteen years at Melrose Wakefield Hospital and its parent corporation, Hallmark Health Systems. (Complaint ¶ 2) In the complaint, Karvelas accuses the

defendants of using a variety of schemes to "knowingly" collect money under Medicare and Medicaid they were not entitled to, in violation of subsections (a)(1) and (a)(2) of the 31 U.S.C. § 3729 of the False Claims Act.

Mr. Karvelas' complaint arose out of concern about patients who were in danger because the hospital was not providing basic health services — with respirators, sleep apnea studies, oximetry, mechanical ventilation, ventilators being changed without orders (Complaint ¶ 104), chest pulmonary therapy, stress testing, arterial blood gas testing, and with patient care. (Complaint ¶ 93, 100.) Furthermore, Karvelas knew the Hospital was billing the Government and obtaining Medicare and Medicaid reimbursement for "services" not being provided. In the complaint John Karvelas sets forth, in specific detail, sixteen different schemes that Karvelas witnessed as a respiratory therapist — when he saw the tragic consequences of services, prescriptions and medical equipment at every level of patient care in the hospital not being provided.

The specifics in each of these schemes are described in detail in paragraphs 96 through 418 by John Karvelas from what he witnessed as a care provider at the hospital, reviewing patients' charts and treating patients in the respiratory care unit.

In the first section of the complaint, the plaintiff painstakingly describes the process for submitting bills to both Medicare (Complaint ¶¶ 11-52) and Medicaid (Complaint ¶¶ 53-72). Key sections in that process have to do with what the hospital is legally obligated to certify in order to obtain Government funding in the

process for Medicare or Medicaid reimbursement. (Complaint ¶ 33) Every Hospital, when it submits any document to the Government for reimbursement by Medicare, is required to complete a "Certification" requirement. This certification required that (Complaint ¶ 37) in order to receive Medicare reimbursement, that the filed report is (1) truthful, (2) correct, and (3) complete.

The Complaint alleges that the defendants were required to certify cost reports as follows. (Complaint ¶ 38):

> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. 42 C.F.R. § 413.24. See also HCFA Form 2552.

In each of the paragraphs numbered 96 through 418, the relator describes in detail how he knew, from his experience at the hospital, that the Government was being billed inappropriately for Medicare reimbursement by the Hospital, in violation of the False Claims Act.

Because of space limitations, this petition will focus on two of the sixteen schemes:

In Scheme H, the plaintiff Karvelas alleges that a wealthy donor, who was a trustee of the defendant Melrose Wakefield Hospital and who had donated millions of dollars to the Hospital, became a patient

with a respiratory problem. The Scheme is described as follows: The blood oxygen level at discharge is used to determine if there is a medical necessity under Medicare and Medicaid for reimbursement by the Government for out patient oxygen equipment prescribed by the Hospital at discharge. (Complaint ¶ 326). If the patient's blood oxygen saturation level is above 85% on the date of discharge, the patient does not meet the criteria for medical necessity and Medicare will not pay for the oxygen equipment. If the saturation baseline number is at 85% or lower, the patient will qualify for home oxygen under Medicare, and the Government will pay for it. (Complaint ¶ 326)

The wealthy patron's saturation level at discharge was higher than the 85%. Therefore, she did not qualify for an oxygen concentrator at home.

The appellant focuses on this one particular patient to demonstrate an overall scheme involving medical necessity — that patients of the hospital routinely were referred for home care oxygen by the hospital staff using numbers at acute state of illness rather than at the baseline on date of discharge.

In September 1994, when the woman was being discharged, the relator and other Respiratory Therapists received a call from the administration of the hospital, instructing the relator and others in the Respiratory Therapy department to do whatever they had to do no matter what to get the trustee/patient qualified for home oxygen so that Medicare would pay for it. (Complaint ¶ 332). An employee of the defendant Hospital then falsified the oximetry results to justify the need for home oxygen to get the physician to write

a prescription for home oxygen, even though the patient did not qualify for it. Medicare paid for the home oxygen concentrator for over three years, for oxygen where there was no medical necessity under the rules of Medicare. On January 26, 1997, the wealthy donor/trustee admitted to the Relator that the results were falsified. (Complaint ¶ 332). And the hospital continued to falsify test results for other patients. These are the facts that support the allegations of false billing in Scheme H.

Scheme B relates to falsely certifying arterial blood gas testing equipment. In Scheme B, Karvelas alleges that the hospital performed blood tests with machinery and equipment that was not tested, or certified, and therefore did not adhere to the laboratory's quality control policies, and, further, did not document all quality control activities, or instrument and procedural calibrations and maintenance standards (Complaint ¶ 155). Therefore the blood test results were bogus and unreliable and should not have been billed to Medicare. (Complaint ¶ 151)

Quality controls were supposed to be run at the beginning of every 8-hour work shift in each arterial blood gas test machine prior to any blood being analyzed. Without these calibrations the defendants were not entitled to Medicare/Medicaid reimbursements for these tests.

The lab performed approximately 21,000 ABG tests in the three-year period beginning in June, 1994 through April, 1997 at $50.00 per test, and the defendant Melrose Wakefield Hospital billed Medicare

and Medicaid for the costs of these tests on a large percentage of these patients, with each bill certified to Medicare or Medicaid that the ABG laboratory had in fact complied with standards promulgated by the College of American Pathologists (CAP) or the Government pursuant to the Clinical Laboratory Improvement Amendments (CLIA). The ABG laboratory never met either the CAP or the CLIA standards. (Complaint ¶ 170).

The Hospital ignored calibration verification procedures and omitted failed equipment maintenance and function checks. The machinery for the testing was out of service, and did not fall within the range of proficiency required for the testing. The membranes on the testing system were blown. The ABG reports and printouts and charts and all reports resulting from the Blood Gas testing were false, and the bills submitted to Medicare and Medicaid were falsely certified as having been the result of equipment which had been certified and tested. (Complaint ¶¶ 167-168). Because of the foregoing falsely claimed items, the Government paid for bogus testing as far as the analysis of arterial blood gases was concerned. (Complaint ¶ 168).

Yet, even though the defendants knew these calibrations were not being run, they "knowingly" violated section 3729(a) in two regards: By knowingly presenting claims to the Government for payment that were based on the false calibrations violating 31 U.S.C. § 3729(a)(2). They also "knowingly" obtained payments using these falsely certified reports, in violation of 31 U.S.C. § 3729(a)(2). (See Complaint ¶ 157).

The Court of Appeals overlooked all the facts that were alleged to have formed the basis for the false claims. Relying instead on the draconian fraud standards of rule 9(b), the Court concentrated on the paperwork involved in the submission of the claims to Medicare, and ruled that Karvelas had not stated the particulars in any of the paperwork that was sent in support of the hospital's claims for payment.

Yet from the falsification of oximetry results to the ABG schemes, as well as to all the other schemes alleged in the Complaint, Karvelas presented the factual details that formed the basis for the "knowing" submission of claims that were presented to the United States Government in violation of 31 U.S.C. § 3729(a)(1).

Likewise they were "knowingly" using false records to get false claims paid or approved in violation of 31 U.S.C. § 3729(a)(2). Accordingly the relator filed suit in accord with the procedure set forth in 31 U.S.C. § 3730.

SUMMARY OF ARGUMENT

First, with the False Claims Amendments of 1986, Congress changed the requirements for false claims cases. Claims no longer require proof of fraud. Instead, Congress mandated the use of "knowing" misrepresentation when examining false claims cases. These statutes require that the plaintiff show that the defendant "knowingly" presents a false or fraudulent claim or that they "knowingly" used a false record to get a false or fraudulent claim paid or approved. Karvelas showed overwhelmingly in each scheme the

underlying facts behind the knowing submission of a false claim.

Second, the use of the standard of heightened pleadings for claims of fraud violates the False Claims Act. The Supreme Court has stated that the basic rule for federal pleading is the broad notice pleading standard found in Federal Rule 8(a). For fraud cases, the heightened pleading standard of Rule 9(b) is not required.

The First Circuit erred in rejecting this claim on the grounds that (1) allegations were made that the False Claims Act is not a fraud statute and (2) all the courts are following the heightened pleadings standard. To start with the False Claims Act is more than just a fraud statute. Yes it is a fraud statute, but Congress has widened its reach so that it now encompasses more than actual fraud. Second, it is important that the issue of a heightened pleadings standard be examined by this Court. For if in fact the circuit courts are applying that standard to False Claims cases, they are deviating from the course mandated by the Congress.

This case involves an important issue for which certiorari is needed. Congress has clearly mandated that the heightened standards for fraud are inappropriate in False Claims actions, and it is essential to treat false claims cases as issues of knowledge, not of fraud. In examining the false claims it is essential to judge the pleadings on whether or not the defendant "knowingly" misrepresented the facts in submitting claims to Medicare.

REASONS FOR GRANTING THE WRIT

I. IN THE 1986 FALSE CLAIMS REFORM ACT CONGRESS SOUGHT TO REJUVENATE THE QUI TAM PROVISIONS OF THE FALSE CLAIMS ACT BY [1] ALLOWING RECOVERY FOR PRESENTING "KNOWINGLY" FALSE CLAIMS, [2] BY ELIMINATING "SPECIFIC INTENT" AS A NECESSARY ELEMENT FOR RECOVERY, AND [3] BY ELIMINATING THE NECESSITY OF PROVING THE CASE BY "CLEAR AND CONVINCING" EVIDENCE, UNDER THE FALSE CLAIMS ACT.

In the mid-1980s Congress was faced with significant examples of abuse and fraud by government contractors. The media reported Government purchases of $400 hammers, $7,000 coffeepots, $660 socket wrenches $16,571 lunch refrigerators, $640 toilet seats, and anti-aircraft guns that do not work. According to Senate Report 99-345:

> "Fraud permeates all government programs ranging from welfare and food stamp benefits, to multimillion dollar defense procurements to crop subsidies and disaster relief programs."

Id., at 2, App. 226a. The result was a GAO report that concluded:

> "The sad truth is that crime against the Government often **does** pay."

Id., at 3, Appendix, at 229a. Congress responded to this with the 1986 False Claim Amendments.

Congress revised and overhauled the False Claims Act with a view to eliminating "litigative hurdles" to make the qui tam remedy of the False Claims Act more effective. S. Rep. 99-345, at 6-7. Appendix, at 223a. To make the statute "a more useful tool" against fraud in "modern times," Congress decided to further encourage qui tam actions.

> The Committee's amendments contained in [the bill that ultimately became the False Claims Reform Act of 1986] are aimed at correcting restrictive interpretations of the act's liability standard, burden of proof, qui tam jurisdiction and other provisions in order to make the False Claims Act a more effective weapon against government fraud.

Appendix, at 230a.

One of the central features of these amendments was the relaxation of the "mental element" of the claims brought under the False Claims Act.

> "The False Claims Reform Act ... defines the mental element required for a successful prosecution and clarifies the burden of proof in civil false claims actions."

Appendix, at 226a.

More specifically Congress eliminated the necessity of proof of actual fraud as an element of recovery under the False Claims Act, doing so in three different ways:

First, the basic difference in fraud and misrepresentation is the intent of the defendant. The words fraud or deceit imply an illegal purpose or guilty intent. Cf. DOUGLAS B. WRIGHT, JOHN R. FITZGERALD & WILLIAM L. ANKERMAN, CONNECTICUT LAW OF TORTS § 137, at 393 (3d Ed. 1991). See also RANDOM HOUSE WEBSTER'S UNABRIDGED DICTIONARY (2d Ed. 1997), defining 'deceit' as an "intentional concealment or perversion of the truth." Pre-1986 False Claims case law required that, to show a violation of the False Claims Act the evidence must demonstrate "guilty knowledge of a purpose on the part of [the defendant] to cheat the Government," or "knowledge or guilty intent," *United States v. Aerodex, Inc.*, 469 F.2d 1003 (5th Cir. 1972). See also *United States v. Mead*, 426 F.2d 118 (9th Cir., 1970), *United States v. Ueber*, 299 F.2d 310 (6th Cir. 1962), *United States ex rel. Brensilber v. Bausch & Lomb Optical Co.*, 131 F.2d 545 (2d Cir. 1942), aff'd, 320 U.S. 711 (1943).

The False Claims Reform Act expressly rejected specific intent as an element of an FCA action. In doing so the 1986 FCA Amendment overruled the rule of *United States v. Aerodex, Inc.*, 469 F.2d 1003 (5th Cir. 1972), and similar cases. After the False Claim Reform Act, proof of fraud is no longer required, and there is no requirement that, to be actionable, the evidence in the False Claim case must show the defendant's "specific intent" to defraud the plaintiff.

The enactment of the Reform Act 31 U.S.C. § 3729(b)was very clear: In unequivocal terms the False Claims Act now provides that:

"[N]o proof of specific intent is required."

Appendix, at 226a.

In contrast to the inquiry in a fraud case, after the 1986 Amendments the focus is on the defendant's knowledge – whether the defendant knew the claim was false – not on whether the evidence showed a guilty purpose of defrauding the Government.

Second, the 1986 Amendments make it clear that the standard to be applied in FCA cases is whether the defendant had actual or constructive knowledge of the false nature of the claim being submitted. Even the most cursory view of 31 U.S.C. § 3729(a)(1) and § 3729(a)(2) shows that liability turns on whether the defendant acted "knowingly," i.e., with knowledge of the falseness of the claim. Because the False Claims Reform Act puts the statutory emphasis on the defendant's knowledge, not his intent, the False Claims Reform Act actually provided statutory definitions for "knowing" and "knowingly," as those terms are used in the False Claims Act. See U.S.C. § 3729(b). Thus, after the 1986 Amendments the statutory focus is on the defendant's knowledge of the claim's falsity, not whether the plaintiff could prove technical fraud.

Third, the 1986 Amendment rejected the traditional rule for the burden of proof in fraud cases. The traditional rule is that the fraud must be shown by clear and convincing evidence. See, e.g., *Manchel v.*

Kasdan, 286 App. Div. 483, 144 N.Y.S.2d 694 (1st Dep't 1955) ("To make out a case of fraud ... the evidence must be clear and convincing and the inference of fraud unequivocal."). The 1986 Amendments expressly overruled judicial decisions applying a heightened fraud burden of proof for False Claims cases. In doing so, Congress rejected the holdings of *United States v. Ueber*, 299 F.2d 310, 314 (6th Cir. 1962) ("clear, unequivocal and convincing evidence"); *Hageny v. United States*, 570 F.2d 924, 933 (Ct. Cl. 1978); *United States v. Milton*, 602 F.2d 231, 233 (9th Cir. 1979) ("clear, explicit and unequivocal evidence"); *United States v. Foster Wheeler Corp.*, 447 F.2d 100, 101 (2d Cir. 1971) ("clear and convincing"). By eliminating the heightened burden of proof for fraud cases, the False Claims Reform Act further indicated its intent to make liability turn on the defendant's knowledge of the claim's falsity, not the defendant's intent to defraud the Government.

In short, to make the False Claims Act more effective, the 1986 Amendment eliminated the requirement that the plaintiff must prove actual fraud in order to recover under 31 U.S.C. §§ 3729(a)(1), (a)(2). Instead, the 1986 Amendments substituted a knowledge standard for the pre-1986 fraud standard. Thus, under the False Claim Reform Act the question presented is not whether the defendant was guilty of fraud, but rather his knowledge of the falsity of the claim being presented. Those statutes require that the plaintiff show that the defendant "knowingly" presents a false or fraudulent claim (31 U.S.C.§ 3729(a)(1)) or that he "knowingly" used a false record to get a false or fraudulent claim paid or approved (31 U.S.C. § 3729(a)(2)).

Despite the statutory emphasis on the defendant's knowledge, the First Circuit focused on whether the complaint set forth allegations of fraud with particularity.

II. SINCE RECOVERY UNDER F.C.A. §§ 3729(a)(1),(a)(1) DEPENDS UPON THE DEFENDANT'S KNOWLEDGE OF THE FALSITY OF THE CLAIM, AND NOT UPON THE HIS INTENT TO DEFRAUD THE GOVERNMENT, RULE 9(b)'S SIMPLIFIED PLEADING STANDARD, WHICH ALLOWS "KNOWLEDGE" TO BE PLEADED GENERALLY, APPLIES. THE HEIGHTENED PLEADING STANDARD, WHICH APPLIES ONLY TO "AVERMENTS OF FRAUD," DOES NOT APPLY.

A. Because the Complaint Does not Include an "Averment of Fraud," The *Swierkiewicz* Principle Prohibits the Application of a Heightened Pleading Standard.

The decision in the Court of Appeals turned on whether the relator's complaint was sufficiently particular, within the meaning of Federal Rule 9(b), to set forth a claim. Yet, under the False Claims Reform Act of 1986, the state of mind required to be shown does not require particularity under Rule 9(b). Since the first two counts only require a showing of "knowledge" and do not constitute "averments of fraud," the complaint is not required to state the "circumstances constituting fraud." Accordingly the Court of Appeals erred in dismissing the case on the pleadings.

To determine whether particularized pleading is required under the Federal Rules, we examine the complaint to determine the "condition of mind" required to be shown. If the complaint is an "averment of fraud or mistake" the pleader is required to "state the circumstances constituting fraud or mistake with particularity." Any other condition of mind may be averred generally.

With this dichotomy in mind we now examine this complaint. This case involves only the first two counts of the relator's complaint. These counts assert violations of 31 U.S.C. §§ 3729(a)(1), (a)(2). More specifically, Count One asserts that the defendants "knowingly" presented false or fraudulent claims to the Government for approval or payment in violation of 31 U.S.C.§ 3729(a)(1). That statutory provision does not require the plaintiff to show that the defendant intended to defraud the Government. It imposes liability for "knowingly" presenting a "false" claim. The statute is quite specific:

> "Any person who ... knowingly presents, or causes to be presented, to an officer or employee of the United States Government ... a false or fraudulent claim for payment or approval. ..."

31 U.S.C. § 3729(a)(1), see Appendix 221a.

This section details only three elements necessary to establish liability. There must be: (1) a false or fraudulent claim; (2) that was presented, or caused to be presented, to the United States; and (3) with knowledge that the claim was false. The state of

mind required to establish liability depends on proof of the defendant's knowledge, not on proof of its fraudulent intent.[1]

Count Two also does not does not require proof of fraudulent intent. Count Two is based on 31 U.S.C. § 3729(a)(2). That statute imposes liability under the False Claims Act against

> "Any person who ... knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government. ..."

31 U.S.C. § 3729(a)(2), Appendix 221a.

Under Count Two, the defendants are liable if they "knowingly" used false records to get false or fraudulent claims paid or approved. While the evidence must show the defendant knew the claim was false, it does not require a showing that the defendant had a fraudulent purpose. Thus, like the first count, Count Two, the allegation under section 3729(a)(2) also does not require a showing of fraudulent intent. It imposes liability for "knowingly" using a false record to get the Government to pay a false claim.

Under either Count One or Count Two, the

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[1] More recent federal cases have refused to construe statutes in such a way that an 'intent to defraud' is imported into a statute with nothing in the text, structure or history of the act to warrant such importation. *Bates v. United States*, 522 U.S. 23 (1997).

condition of mind required to be shown by the allegation is the defendant's knowledge of the falsity of the claim, not his intent to defraud. Federal Rule 9(b) sets forth the degree of specificity required. The Rule specifies that

> In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

Appendix, at 223a.

Both counts require a showing of the defendants' knowledge. While knowledge is a "condition of mind," it is not an "averment of fraud." Therefore, under Rule 9(b), either of these counts can be pleaded generally.

Despite the clear import of Rule 9(b) – specifying that because False Claims cases under section 3729(a)(1) or 3729(a)(2) deal with the defendants' knowledge, they can be pleaded generally – the First Circuit imposed a "heightened" pleading standard. Even though the issue is knowledge and not fraud, the First Circuit applied the heightened pleading standard that applies only to averments of fraud, holding that "the circumstances constituting fraud" must be "stated with particularity."

In applying this heightened standard, the Court of Appeals violated the principles set forth by this Court in *Swierkiewicz v. Sorema, N.A.*, 534 U.S. 506 (2002), in which this Court held that the Federal Rules

should be applied literally. The basic rule for federal pleading is the broad notice pleading standard found in Federal Rule 8(a), which requires only a "short and plain statement" showing that the pleader is entitled to the relief requested. Only for "averments of fraud" or "averments of mistake" is there a heightened standard of pleading. In those cases the pleader must state the "circumstances constituting fraud or mistake...with particularity." In nonfraud or nonmistake matters, to apply the heightened pleading standard of Rule 9(b) would contravene the *Swierkiewicz* principle. A requirement of greater specificity in other cases "must be obtained by the process of amending the Federal Rules, and not by judicial interpretation." 534 U.S., at 515.

In *Swierkiewicz*, the Supreme Court reasoned that the "simplified pleading standard" of Rule 8(a) applies to all civil actions, with "limited exceptions." 534 U.S., at 513. The Second Circuit was reversed in *Swierkiewicz* for relying on "settled precedent" in affirming the dismissal of an employment discrimination case because the plaintiff's complaint had not alleged particularized facts constituting a prima facie case of discrimination. Finding that "imposing the heightened pleading standard in employment cases conflicts with the simplified pleading requirement of Rule 8(a)(2), the Supreme Court reversed, holding that extending the requirements of particularity in pleading beyond the text of the Federal Rules must be accomplished by amending the Rules, not by judicial interpretation. As this Court held in *Swierkiewicz*,

> "A requirement of greater specificity for particular claims is a result that must be

> obtained by the process of amending the Federal Rules, and not by judicial interpretation."

534 U.S., at 515. When the literal approach mandated by *Swierkiewicz* is applied to pleadings in False Claims Act qui tam cases, it is clear that the Rules do not specify a heightened standard of pleading beyond the simplified pleading requirement set forth in Rule 8(a). Imposing a heightened standard beyond Rule 8 violated the *Swierkiewicz* principle. It should be reversed.

B. The First Circuit's Reasons for Imposing the Heightened Pleading Requirement Violate the *Swierkiewicz* Principle.

The three reasons given by the First Circuit do not justify its conclusion that particularized pleading is required. To the contrary, these three arguments essentially disregarded the holding of this Court in *Swierkiewicz v. Sorema, N.A.*, 534 U.S. 506 (2002).

First, the Court of Appeals argued that, since *Swierkiewicz* had recognized Rule 9(b) as an exception to the simplified usual pleading standard of Rule 8, the Court of Appeals could simply apply Rule 9(b) without any conflict with *Swierkiewicz*. Such an argument misses the point of *Swierkiewicz*. Although the *Swierkiewicz* case recognized that Rule 9(b) as a narrow exception to the simplified pleading standard, it did not hold that particularized pleading is required whenever Rule 9(b) is invoked. Rule 9(b) provides two rules: It requires particularized pleading for "averments of fraud or mistake," but any other

"condition of mind" can be "averred generally."[2] As this Court noted in *Swierkiewicz*, the simplified pleading rule of Rule 8 does not apply to allegations that are not averments of fraud or of mistake. In this case the False Claim Reform Act of 1986 made it clear that the complaint's allegations are not "averments of fraud." Instead the allegations of Count One and Two refer to the defendants' "knowledge" of the falsity of the claims being submitted to the Government, not fraud. (Rule 9(b) allows "knowledge" to be averred generally). See Appendix, at 223a.

The Court of Appeals next argument is that, because the False Claims Act is an antifraud act, any claim under that Act requires particularized pleading.[3]

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[2] *Swierkiewicz* rejected any extension of 9(b)'s limited exceptions: "Rule 9(b) ... provides for greater particularity in all averments of fraud and mistake. This Court has declined to extend such exceptions to other contexts." 503 U.S., at 513.

[3] The Court of Appeals stated that "We do not agree ... that the False Claims Act is not a 'fraud statute,' " see Appendix at 9a, pointing out that one of the FCA's basic purposes was to combat fraud and corruption in Government programs. The Court of Appeals then leaps from the characterization of the Act as a antifraud statute to the conclusion that any claim under the FCA is an "averment of fraud" under Rule 9(b). The leading commentators have recognized that, even though the False Claims Act was intended to combat fraud and corruption in Government programs, to the extent that the False Claims Act does not require proof of fraud as a prerequisite to recovery, it is not a fraud act. See JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS page 2-5 (2d Ed. 2000, supp. 2003-1) ("The False Claims Act is not a fraud statute."); JAMES B. HELMER, JR., FALSE CLAIMS ACT 357 (3d Ed. 1999) ("A False Claims Act case is *not* a fraud case."). See also *United States ex rel. Johnson v. Shell Oil Co.*, 183 F.R.D. 204, 208 n.6 (E.D. Tex. 1998)("The False Claims Act is not a fraud statute.").

Such an argument misses the function of Rule 9(b). While one of the purposes of the False Claims Act is to combat fraud and corruption in Government programs, Congress did not limit itself to cases in which the evidence showed fraud. Recognizing that "detected fraud is ... an imprecise measure of how much actual fraud exists," S. Rep. 99-345, Appendix 224a-259a, at 226a, Congress cast its net more broadly.[4] By eliminating the requirement of showing "specific intent," the 1986 Amendments recognized that the False Claims Act can apply beyond fraud cases. That is the False Claims Act can apply even if the evidence does not show specific fraudulent intent. Fraud is no longer the sine qua non. Because there is no "specific intent" requirement the False Claims Act can also apply in cases where the defendant is charged with "knowingly" filing a false claim or "knowingly" using a false claim to obtain payment.

Finally, the First Circuit noted that other circuits have required particularized pleading for False Claim cases. While several circuits formerly required particularized pleading for qui tam cases, none of these courts considered or applied that particularized pleading to a claim under 31 U.S.C. § 3729(a)(1) or § 3729(a)(2) in the face of an argument based on this Court's decision in *Swierkiewicz*. To require particularized pleading in False Claim cases after

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[4] For a recent example of Congress acting a statute more broadly than its most limited purpose, see *Sabri v. United States*, 03-44 (U.S. 2004) (holding that, because Congress can control federal spending, it can outlaw bribes to state and local officials for municipalities receiving federal funds without showing a nexus between the federal funds and the bribe).

Swierkiewicz would be a clear way to ignore that holding. It is only anther way to impose "needless litigative hurdles," in violation of the strong congressional mandate of the False Claim Reform Act. Just as the 1986 Congress rejected numerous pre-1986 cases requiring "specific intent" as overly restrictive and inappropriate, the Court should accede to the legislative intent, thus avoiding unnecessary conflict between the legislative and judicial branches of government.

III. BY IMPOSING HEIGHTENED PLEADING STANDARD TO THIS COMPLAINT, THE COURT OF APPEALS DISREGARDED CONGRESSIONAL INTENT TO ELIMINATE "LITIGATIVE HURDLES" FOR QUI TAM CLAIMS.

This case involves more than a technical question of legal pleadings. It involves the core question of whether the courts will give full effect to the Congressional intent in passing the False Claim Reform Act of 1986. It is the duty of the judiciary to enforce the legislative intent of a statute, as expressed in the statutory language.

The problem with the decision below is that it cuts the heart out of one of the principal purposes of the False Claims Reform Act of 1986. Instead of eliminating unnecessary "litigative hurdles," the Court of Appeals imposed an additional — and unnecessary — hurdle not required by the Federal Rules. The False Claims Reform Act was not a minor technical correction of the False Claims Act; it was a wholesale overhaul of the statute. To make the qui tam remedy "a more useful

tool" against fraud in "modern times," the Reform Act sought to eliminate unnecessary "litigative hurdles."

By unnecessarily imposing a particularized pleading requirement the First Circuit imposed precisely the same type of litigative hurdle the 1986 Amendments were designed to preclude. In doing so the First Circuit disregarded a strongly stated congressional purpose in passing the False Claims Reform Act.[5] Because the judiciary should implement congressional intent instead of thwarting it, the issue presented is important and merits the consideration of this Court. This Court should grant certiorari to allow Congress' intent to be carried out. In passing the False Claims Reform Act, Congress assailed the judicial dilution the impact of the original Act. Recent commentators have again noted that the same type of retrenchment seems to presently be occurring with the 1986 Reforms.[6]

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[5] The significance of particularized pleading as a litigative hurdle is shown by the most recent issue of FALSE CLAIMS ACT AND QUI TAM QUARTERLY REVIEW. Of the 31 decisions reported in the April 2004 issue, ten involved the issue of particularized pleading. Nine of the ten pleading were found to lack particularity. Only one of the ten challenged pleadings was deemed to be sufficiently particular. *United States ex rel. Allen v. Beta Constr.*, 2004 U.S. Dist. LEXIS 4743 (D.D.C. 2004).

[6] Gregory G. Bookes, *The False Claims Act: Congress Giveth and the Courts Taketh Away*, 25 HAMLINE L. REV. 373, 399-400 (2002) ("In 1986, Congress acted to erase decades of court decisions that unduly restricted the scope and breadth of the FCA. ... Recent judicial interpretations ... [again] frustrate the goal of the FCA and impair the effectiveness of the Act. ... Congress may be forced to once again enact amendments ... to restore the Act. ...").

One of the principal aims of the 1986 Act was the elimination of specific intent as a requirement in FCA qui tam actions. According to the legislative history, it was the view of Congress that the district courts had weakened and undercut the effectiveness of the pre-1986 False Claims Act by a series of overly restrictive judicial decisions. These decisions, in Congress's view, crippled the effectiveness of the FCA by holding that, to authorize qui tam recovery, the evidence had to show the defendant's specific intent to defraud the Government. An example of such case that was discussed in the legislative history was *United States v. Aerodex, Inc.*, 469 F.2d 1003 (5th Cir. 1972). In that case the Fifth Circuit, following cases from a majority of the other circuits, held that

> [T]o show a violation of the False Claims Act the evidence must demonstrate "guilty knowledge of a purpose on the part of [the defendant] to cheat the Government," ... or "knowledge or guilty intent."

469 F.2d, at 1007. The *Aerodex* case was not unique; it was the majority rule. *See, e.g.*, United *States v. Mead*, 426 F.2d 118 (9th Cir. 1970) ("the government must prove that the defendant had the specific intent of deceit."); *United States ex rel. Brensilber v. Bausch & Lomb Optical Co.*, 131 F.2d 545 (2d Cir. 1942), aff'd, 320 U.S. 711 (1943) ("The statute makes fraud ... the basis of liability, and uses the word in its accepted sense of deceit. ... [D]eceit is a sine qua non."). In other words the pre-1986 rule was that without evidence of "specific intent," there could be no recovery under the False Claims Act.

With the mounting evidence of corruption against the Government, Congress concluded that "restrictive court interpretations," such as *Aerodex*, *Mead* and *Bausch & Lomb* had thwarted the broad remedial nature of the False Claims Act. Recognizing that the False Claims Act's remedies were no longer a serious deterrence to unscrupulous contractors, (See 132 CONG. REC. H6478-6479 (Sept. 9, 1986) (remarks of Rep. Glickman)) Appendix 271a-275a, at 272a. Congress determined that it was necessary to take bold steps to rejuvenate the qui tam provisions of the Act.

A central aspect of the 1986 False Claims Act Reform was the inclusion of statutory provisions to define the terms "know" and "knowingly" to eliminate any argument that a specific intent to defraud the Government is a necessary element of a False Claims Act violation. In revising judicial decisions such as the anti-qui tam case[7] of *Bausch & Lomb*, the 1986 reformers expressly stated their intent that the Reform Act eliminate the requirement of specific intent as a prerequisite needed to establish qui tam liability. (See 132 CONG. REC. H6480 (Sept. 9, 1986) (statement by Rep. Fish), Appendix, at 276a-281a; 132 CONG. REC. S11243 (Aug. 11, 1986) (statement by Sen. Grassley.)Appendix, at 260a-270a. The statutory language, intended to eliminate the necessity of proving specific intent, is now found in 31 U.S.C. §

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[7] In holding that specific intent was a necessary element of a False Claims case, the *Bausch & Lomb* court had commented that qui tam actions were "odious and happily nearly obsolete." 131 F.2d, at 547. That view was clearly not shared by the Congressional reformers who passed the 1986 False Claims Reform Act.

3729(b). According to the chief Senate sponsor of the 1986 Act, the practical impact of the new standard was described as the equivalent of "gross negligence." See statement of Sen. Grassley, equating the practical import of the two standards. ("Reckless disregard often is defined as gross negligence and gross negligence frequently is said to require a reckless disregard." Appendix, at 265a.) See also S. Rep. 99-345, at 21, Appendix at 257a.

The Reform Act went further, eliminating the requirement that liability in a qui tam action had to be established by "clear and convincing, or even clear, unequivocal and convincing evidence." See *United States v. Ueber*, 299 F.2d 310 (6th Cir. 1962), the standard of proof traditionally used for fraud cases. Noting Justice Department testimony characterizing this standard of proof as the "functional equivalent of a criminal standard," the authors of the 1986 Reform expressly rejected such a standard. See 31 U.S.C. §§ 3731(c) (requiring proof "by a preponderance of the evidence.").

Notwithstanding this clear statutory mandate, the First Circuit's holding rejected the congressional mandate. To the contrary, the Court of Appeals unnecessarily imposed a requirement of particularized pleading in the face of the *Swierkiewicz* principle. Because the holding below violates the congressional purpose in enacting False Claims Reform Act this court should grant certiorari to remedy the situation.

CONCLUSION

If one attempts to fit the False Claims Act requirements of proof within the language of Rule 9(b), one is immediately struck by the fact that the language Congress chose for the False Claims Act does not impose a requirement that there be a showing of fraud. The False Claims Act is not a "fraud" statute. Instead, liability attaches if the defendant "knowingly" presents a false claim to the Government. It is found in the statute involving "averments of fraud."

The purpose behind the 1986 Amendments to the False Claims Act was clear: Congress wanted to create "a civil remedy designed to make the Government whole" against fraud and other corruption. To this end the 1986 amendments were intended to overrule judicial decisions that created "litigative hurdles" and reinstate the standard that "the Government need only prove that the defendant knowingly submitted a false claim." Congress specifically intended to reverse decisions requiring the Government to prove the "defendant had actual knowledge of fraud" or to establish that the defendant "had specific intent to submit the false claim." See S. Rep. 99-345, Appendix at 235a.

The heightened pleading requirements of Rule 9(b), which applies to "averments of fraud," does not apply to False Claims Act allegations under 31 U.S.C. §§ 3729(a)(1), 3729(a)(2) because the elements of proof for "averments of fraud" as the qui tam cause of action are not the same. While fraud requires specific intent, the qui tam case only requires a showing that the defendant knowingly filed a false claim. Because

Karvelas has sufficiently pleaded the components of False Claims Act violations, the case should be reversed and remanded for consideration on the merits.

Respectfully Submitted,

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No. 03-1901

UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

UNITED STATES OF AMERICA ex rel. JOHN C. KARVELAS,
Plaintiffs, Appellant,

v.

MELROSE-WAKEFIELD HOSPITAL; MELROSE-WAKEFIELD HEALTHCARE CORPORATION; HALLMARK HEALTH SYSTEM, INC.,
Defendants, Appellees.

February 23, 2004, Decided

COUNSEL: Oliver B. Dickins with whom John F. Murphy was on the brief for appellant.

Michael K. Fee with whom Ropes & Gray LLP were on the brief for appellees.

JUDGES: Before Lipez, Circuit Judge, Coffin, Senior Circuit Judge, and Barbadoro, * District Judge.

OPINIONBY: LIPEZ

OPINION: LIPEZ, Circuit Judge. Plaintiff John C. Karvelas brought this qui tam action against defendants Melrose-Wakefield Hospital, Melrose-Wakefield Healthcare Corporation, and Hallmark Health System, Inc., alleging violations of the False Claims Act ("FCA"), 31 U.S.C. § 3729, et seq. The

district court granted the defendants' motion to dismiss the action for failure to state a claim pursuant to Fed. R. Civ. P. 12(b)(6). On appeal, Karvelas complains that the court wrongly applied the particularity pleading requirements of Fed. R. Civ. P. 9(b) for averments in fraud to this FCA case. He further argues that the court wrongfully dismissed his claim of retaliation by the defendants for conduct protected by the FCA. After examining the issues raised by this appeal, some of which have not been addressed before in this circuit, we affirm.

I.

John C. Karvelas was employed as a respiratory therapist at the Melrose-Wakefield Hospital in Melrose, Massachusetts, from 1982 until January 1997. He claims that from 1994 until the termination of his employment at the hospital in 1997, the defendants knowingly submitted false claims to the United States government in order to obtain Medicare and Medicaid payments, in violation of the False Claims Act. In essence, Karvelas alleges that Melrose-Wakefield Hospital and its parent corporations failed to comply with federal standards for patient care as required by the Health Care Financing Administration ("HCFA") n1 for Medicare and Medicaid reimbursement. He claims that the defendants falsely certified that they were in compliance with these standards and "wrongfully billed Medicare and/or Medicaid," presumably on the basis of services that were being provided improperly or not at all. Karvelas further claims that he was discharged in retaliation for his investigation of the defendants' noncompliance with regulatory standards and violations of the FCA.

On April 6, 2001, Karvelas filed the present qui tam action against the defendants in the United States District Court for the District of Massachusetts. n2 On May 3, 2002, the United States gave notice that it did not intend to intervene in the case. The district court then ordered the complaint unsealed and authorized service on the defendants. The defendants subsequently moved to dismiss the case for failure to state a claim under Fed. R. Civ. P. 12(b)(6). The district court granted the motion and dismissed the case with prejudice, ruling that Karvelas had not met the requirement under Fed. R. Civ. P. 9(b) that allegations of fraud be stated with particularity. n3 It further held that Karvelas had failed to allege facts sufficient to state a claim for False Claims Act retaliation. n4 This appeal followed.

II.

A. Standard of Review

We review de novo the district court's dismissal for failure to state a claim under Fed. R. Civ. P. 12(b)(6). Morales-Villalobos v. Garcia-Llorens, 316 F.3d 51, 52 (1st Cir. 2003). We accept the plaintiff's well-pleaded facts as true and draw all reasonable inferences in favor of the plaintiff. Doran v. Mass. Turnpike Auth., 348 F.3d 315, 318 (1st Cir. 2003). However, we reject claims that are made in the complaint if they are "bald assertions" or "unsupportable conclusions." Arruda v. Sears, Roebuck & Co., 310 F.3d 13, 18 (1st Cir. 2002). Our objective is "to determine whether the complaint . . . alleges facts sufficient to make out a cognizable claim." Carroll v. Xerox Corp., 294 F.3d 231, 241 (1st Cir. 2002). In making this determination, we may affirm on any

independently sufficient basis. Id.

B. The False Claims Act

The False Claims Act, 31 U.S.C. § 3729 et seq., prohibits the submission of false or fraudulent claims to the federal government. The statute was first adopted during the Civil War in response to widespread fraud in wartime defense contracts. See Vt. Agency of Natural Res. v. United States ex rel. Stevens, 529 U.S. 765, 781, 146 L. Ed. 2d 836, 120 S. Ct. 1858 (2000). Its "qui tam" n5 provisions authorized private individuals to sue on behalf of the federal government and were intended to aid the government in discovering fraud and abuse "by unleashing a posse of ad hoc deputies to uncover and prosecute frauds against the government." Harrison v. Westinghouse Savannah River Co., 176 F.3d 776, 784 (4th Cir. 1999)(citation and internal quotation marks omitted). n6

The most recent amendments to the FCA, passed in 1986, see S. Rep. No. 345, 99th Cong., 2d Sess., at 2 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, were intended to encourage the filing of private qui tam actions, yet also included provisions designed to prevent "parasitic" lawsuits, in which "relators, rather than bringing to light independently-discovered information of fraud, simply feed off of previous disclosures of . . . fraud [against the government]." United States ex rel. Siller v. Becton Dickinson & Co., 21 F.3d 1339, 1347 (4th Cir. 1994). The amendments thus represent the latest chapter in a long history of "'repeated congressional efforts to walk a fine line between encouraging whistle-blowing and discouraging opportunistic behavior.'" Prawer, 24 F.3d at 326

(quoting Quinn, 14 F.3d at 651).

The FCA imposes liability upon persons who 1) present or cause to be presented to the United States government, a claim for approval or payment, where 2) that claim is false or fraudulent, and 3) the action was undertaken "knowingly," in other words, with actual knowledge of the falsity of the information contained in the claim, or in deliberate ignorance or reckless disregard of the truth or falsity of that information. 31 U.S.C. § 3729(a)(1), (b). The statute does not require proof of specific intent, that is, intent to present false or fraudulent claims to the government. Id. § 3729(b) (stating that "no proof of specific intent to defraud is required" to prove liability under the FCA). The statute further prohibits "conspiracies to defraud the Government by citing a false or fraudulent claim allowed or paid." Id. § 3729(a)(3). Individuals who violate the FCA are liable for civil penalties and double or treble damages plus the costs incurred in bringing the FCA lawsuit. Id. § 3729(a).

Not all fraudulent conduct gives rise to liability under the FCA. "The statute attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the 'claim for payment.'" United States v. Rivera, 55 F.3d 703, 709 (1st Cir. 1995). Evidence of an actual false claim is "the sine qua non of a False Claims Act violation." United States ex rel. Clausen v. Lab. Corp. of Am., Inc., 290 F.3d 1301, 1311 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 154 L. Ed. 2d 774 (2003). Therefore, a defendant violates the FCA only when he or she has presented to the government a false or fraudulent claim, defined as "any request or demand . . . for money or property" where the

government provides or will reimburse any part of the money or property requested. 31 U.S.C. § 3729(c); see also Harrison, 176 F.3d at 785 ("The False Claims Act at least requires the presence of a claim - a call upon the government fisc - for liability to attach.").

As noted above, the FCA's qui tam provisions allow a private individual or "relator" n7 to file a lawsuit alleging FCA violations on behalf of the United States. 31 U.S.C. § 3730. An FCA qui tam action may not be based on publicly disclosed information unless the relator is the original source of that information. Id. § 3730(e)(4)(A). The relator must first serve his or her complaint upon the government, where it remains under seal for sixty days. Id. § 3730(b)(2). If the government elects to intervene, it takes over the suit and adopts any or all of the allegations contained in the qui tam complaint, in which case the relator is entitled to 15-25 percent of any proceeds recovered. Id. § 3730(c)(1), (d)(1). If the government does not exercise its right to intervene in the suit, the relator may serve the complaint upon the defendant and proceed with the action. Id. § 3730(b)(2), (b)(4)(B), (c)(3). If the relator succeeds in recovering funds for the government, he or she is entitled to 25-30 percent of the recovery. Id. § 3730(d)(2).

C. Failure to Plead Fraud with Particularity

We must consider whether the district court erred in dismissing Karvelas's complaint on the ground that it failed to plead fraud with particularity as required by Rule 9(b) of the Federal Rules of Civil Procedure. Karvelas claims that a complaint stating a violation of the False Claims Act need not comply with Rule 9(b).

He argues in the alternative that Rule 9(b)'s particularity requirements should be relaxed in his case. Finally, Karvelas claims that even if we do not relax these requirements, his complaint alleges fraud with sufficient particularity to satisfy Rule 9(b). After first describing generally the requirements of Rule 9(b), we address each of these arguments in turn.

1. Federal Rule of Civil Procedure 9(b)

Under the general pleading requirements of the Federal Rules of Civil Procedure, a federal civil complaint need only state "a short and plain statement of the claim showing that the plaintiff is entitled to relief." Fed. R. Civ. P. 8(a). However, the federal rules recognize limited exceptions to Rule 8(a)'s simplified pleading standard. For example, claims of fraud are subject to the heightened pleading requirements of Federal Rule of Civil Procedure 9(b), which provides: "In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind may be averred generally."

We have said that Rule 9(b) requires that a plaintiff's averments of fraud specify the time, place, and content of the alleged false or fraudulent representations. Arruda, 310 F.3d at 18-19. The purpose of this requirement is to "give notice to defendants of the plaintiffs' claim, to protect defendants whose reputation may be harmed by meritless claims of fraud, to discourage 'strike suits,' and to prevent the filing of suits that simply hope to uncover relevant information during discovery." Doyle v. Hasbro, Inc., 103 F.3d 186, 194 (1st Cir. 1996).

We have recognized that, under Rule 9(b), a plaintiff may make allegations of fraud on the basis of personal knowledge or on "information and belief." New England Data Services, Inc. v. Becher, 829 F.2d 286, 288 (1st Cir. 1987). Hence, such "information and belief" allegations remain subject to the particularity requirements of Rule 9(b). Moreover, allegations of fraud made on information and belief are also subject to the additional requirement that "the complaint set[] forth the facts on which the belief is founded." Id.; see also In re. Cabletron Sys., Inc., 311 F.3d 11, 28 (1st Cir. 2002) (noting that "this circuit imposed a strict requirement [on security fraud allegations based on information and belief] under 9(b) before enactment of the PSLRA [Private Securities Litigation Reform Act]")(citing Romani v. Shearson Lehman Hutton, 929 F.2d 875, 878 (1st Cir. 1991) ("Where allegations of fraud are . . . based only on information and belief, the complaint must set forth the source of the information and the reasons for the belief.") (superceded by statute)). n8

2. Applicability of Federal Rule of Civil Procedure 9(b) to the FCA

Karvelas argues that the district court erred in granting the defendants' Rule 12(b)(6) motion because a complaint that alleges a violation of the FCA need not comply with Fed. R. Civ. P. 9(b)'s requirement that "in all averments of fraud . . . the circumstances constituting fraud . . . shall be stated with particularity." He claims that the district court should have applied the more lenient general pleading standard of Fed. R. Civ. P. 8(a).

In support of his theory that Rule 9(b) does not apply to

the FCA, Karvelas cites the Supreme Court's decision in Swierkiewicz v. Sorema N.A., 534 U.S. 506, 152 L. Ed. 2d 1, 122 S. Ct. 992 (2002), which held that employment discrimination claims are not subject to a heightened pleading standard. Karvelas's reliance on Swierkiewicz is misplaced. It is true that the Court held in Swierkiewicz that "Rule 8(a)'s simplified pleading standard applies to all civil actions, with limited exceptions." Id. at 513. However, it expressly noted that one such exception is Rule 9(b), which "provides for greater particularity in all averments of fraud or mistake." Id. (emphasis added); see also Leatherman v. Tarrant County Narcotics Unit, 507 U.S. 163, 168, 122 L. Ed. 2d 517, 113 S. Ct. 1160 (1993) (noting that Rule 9(b) imposes a particularity requirement on the pleading of fraud or mistake).

We do not agree with Karvelas that "the False Claims Act is not a 'fraud' statute" and therefore does not fall within the scope of Rule 9(b). Section 3729(a)(1) of the FCA imposes civil penalties when a person knowingly presents or causes to be presented to the government "a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1). Section 3729(a)(3) prohibits any conspiracy "to defraud the Government by getting a false or fraudulent claim allowed or paid." Id. § 3729(a)(3).

The legislative history of the 1986 FCA Amendments and the Supreme Court's interpretations of the statute further support the conclusion that FCA claims involve "averments of fraud" that must be pled with particularity under Rule 9(b). See, e.g., Vt. Agency of Natural Res., 529 U.S. at 781 n.10 (noting "the unobjectional proposition . . . that the FCA was

intended to cover all types of fraud") (emphasis in the original); United States v. Neifert-White Co., 390 U.S. 228, 233, 19 L. Ed. 2d 1061, 88 S. Ct. 959 (1968)("[The FCA] protects the funds and property of the Government from fraudulent claims")(citation and internal quotation marks omitted); United States v. Bornstein, 423 U.S. 303, 309, 46 L. Ed. 2d 514, 96 S. Ct. 523 (1976) (explaining that the FCA was originally enacted to stop "the massive frauds perpetrated by large contractors during the Civil War"); S. Rep. No. 99-345, at 6, reprinted in 1986 U.S.C.C.A.N. at 5271 (describing the FCA as "a civil remedy designed to make the Government whole for fraud losses"). In short, "it is self-evident that the FCA is an anti-fraud statute." Gold v. Morrison-Knudsen Co., 68 F.3d 1475, 1476 (2d Cir. 1995).

Moreover, we reject Karvelas's argument that the False Claims Act is not a "fraud" statute because, under the statute, "liability depends on the defendant's knowledge, not on his fraud," and therefore only the second clause of Rule 9(b), which allows knowledge of fraud to be averred generally, applies. Under the FCA, liability depends upon the defendant's act (presentation of a false or fraudulent claim to the United States government) and mental state (knowledge, or deliberate ignorance or reckless disregard of the truth or falsity of the information presented). That Rule 9(b) allows "malice, intent, knowledge, and other condition of mind of a person [to be] averred generally" does not mean that particularity requirements do not apply to FCA claims. Rather, it simply means that a qui tam relator need not plead with particularity allegations concerning defendants' knowledge, reckless disregard, or deliberate ignorance of the submission of false

claims. The characterization of a state of mind, after all, does not lend itself to detailed pleading. On the other hand, the details of the actual presentation of false or fraudulent claims to the government can and must be pled with particularity in order to meet the requirements of Rule 9(b).

Finally, every circuit court that has addressed this issue has concluded that the heightened pleading requirements of Rule 9(b) apply to claims brought under the FCA. See Yuhasz v. Brush Wellman, Inc., 341 F.3d 559, 562-63 (6th Cir. 2003); United States ex rel. Clausen v. Lab. Corp. of Am., Inc., 290 F.3d 1301, 1308-09 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 154 L. Ed. 2d 774 (2003); United States ex rel. Totten v. Bombardier Corp., 351 U.S. App. D.C. 30, 286 F.3d 542, 551-52 (D.C. Cir. 2002); Bly-Magee v. California, 236 F.3d 1014, 1018 (9th Cir. 2001); Harrison v. Westinghouse Savannah River Co., 176 F.3d 776, 783-84 (4th Cir. 1999); United States ex rel. LaCorte v. SmithKline Beecham Clinical Labs., Inc., 149 F.3d 227, 234 (3d Cir. 1998); United States ex rel. Thompson v. Columbia/HCA Healthcare Corp., 125 F.3d 899, 903 (5th Cir. 1997); Gold v. Morrison-Knudsen Co., 68 F.3d 1475, 1476-77 (2d Cir. 1995); see also John T. Boese, Civil False Claims and Qui Tam Actions § 5.04 (2d ed. 2000 & Supp. 2003)("It is widely accepted by courts that because the essence of a False Claims Act is fraud, Rule 9(b) applies to FCA cases. . . . The applicability of Rule 9(b) to qui tam actions is by now beyond dispute."). For the reasons discussed above, we now join this consensus and hold that Rule 9(b) applies to claims under the FCA. Thus, the district court did not err in requiring Karvelas to plead with particularity the defendants' alleged violations of the FCA.

3. Relaxation of Rule 9(b)'s Particularity Requirements

Karvelas argues that even if Rule 9(b) applies to FCA claims, its requirements should be relaxed in his case because the information necessary to plead with particularity is within the possession and control of the defendants. There is some confusion about the meaning of a "relaxed rule of pleading" under Rule 9(b). At times, Karvelas seems to equate a relaxed rule of pleading with pleading on information and belief. The district court, citing the Fifth Circuit's decision in Thompson, 125 F.3d at 903, stated that the effect of a relaxed Rule 9(b) standard is that "fraud may be pled on information and belief." Other courts have adopted this understanding of what it means to relax 9(b)'s pleading requirements. See, e.g., Clausen, 290 F.3d at 1314; United States ex rel. Russell v. Epic Healthcare, 193 F.3d 304, 308 (5th Cir. 1999). However, as we have already explained, see Part II. c.1 supra, we subject "information and belief" pleading under Rule 9(b) to particularity requirements. There is, in other words, no relaxation of the particularity requirement for "information and belief" pleading. Instead, when we refer to the relaxation of Rule 9(b)'s particularity requirements, we refer to an opportunity for the plaintiff to plead generally at the outset and then later amend the complaint, filling in the blanks through discovery. That is the meaning of a relaxed Rule 9(b) standard that we apply here.

For example, we have said that Rule 9(b) pleading standards may be relaxed, in an appropriate case, "when the opposing party is the only practical source for discovering the specific facts supporting a pleader's

conclusion." Boston & Maine Corp. v. Hampton, 987 F.2d 855, 866 (1st Cir. 1993). In such cases, "even for a plaintiff's allegations of fraud, if the facts would be peculiarly within the defendants' control, a court may allow some discovery before requiring that plaintiff plead individual acts of fraud with particularity." Id. (citation and internal quotation marks omitted).

Whether discovery is warranted to correct general pleadings that do not initially meet the requirements of Rule 9(b) may turn on the nature of the statute under which the plaintiff's cause of action arises. For example, we have relaxed Rule 9(b)'s pleading requirements pending further discovery for allegations of mail and wire fraud pursuant to the Racketeer Influenced and Corrupt Organizations Act "because of the apparent difficulties in specifically pleading mail and wire fraud as predicate acts." New England Data Servs., 829 F.2d at 290-91. n9 See N. Bridge Assocs., Inc. v. Boldt, 274 F.3d 38, 44 (1st Cir. 2001)(noting that in the RICO context, where "the specific information [concerning the defendants' use of interstate mail or telecommunications facilities] is likely in the exclusive control of the defendant, the court should make a second determination as to whether the claim as presented warrants the allowance of discovery and if so, thereafter provide an opportunity to amend the defective complaint")(quoting Feinstein v. Resolution Trust Corp., 942 F.2d 34, 43 (1st Cir. 1991)). We have not, however, had occasion to consider whether this relaxation of Rule 9(b)'s pleading requirements should be extended to cases arising under the False Claims Act.

Although some courts have recognized in theory that

the particularity requirements of Rule 9(b) may be relaxed in an FCA qui tam action where the information relevant to the fraud is "'peculiarly within the perpetrator's knowledge,'" United States ex rel. Doe v. Dow Chem. Co., 343 F.3d 325, 330 (5th Cir. 2003) (quoting Russell, 193 F.3d at 308), few courts have actually applied a relaxed Rule 9(b) standard to an FCA qui tam action. See Boese, Civil False Claims and Qui Tam Actions, § 5.04[D] (noting that "rarely some courts will grant qui tam relators 'additional leeway' under Rule 9(b) when information is exclusively in the hands of the defendant"). n10 The district court, quoting the Fifth Circuit's opinion in Russell, 193 F.3d at 308, refused to apply any version of a relaxed standard in this case because "documents containing the requisite information [were] possessed by other entities, such as the Healthcare Financing Administration." This reasoning apparently assumes that where the required information is in the hands of the government, a relator can gain access to those documents and fill in the blanks on that basis. See Clausen, 290 F.3d at 1314 n.25 (refusing to apply a more lenient pleading standard to relator's allegations of fraud because the government had access to the relevant information and the relator was "not without avenues for obtaining [that] information").

However, as Karvelas correctly notes, every FCA qui tam action involves allegations of false or fraudulent claims submitted to the government. In many of these cases, the information needed to fill the gaps of an inadequately pleaded complaint will be in the government's hands. In addition, if the relator seeks to obtain the requisite information from the government, for example by submitting a request under the

Freedom of Information Act (FOIA), he or she may encounter Section 3730(e)(4) of the FCA, which prohibits qui tam actions based upon publicly disclosed allegations unless the relator is an "original source" of that information. 31 U.S.C. § 3730(e)(4)(B); see, e.g. United States ex rel. Mistick PBT v. Housing Auth., 186 F.3d 376, 383 (3d Cir. 1999)(agency report prepared in response to a FOIA request is based upon publicly disclosed information for FCA purposes), cert. denied, 529 U.S. 1018, 146 L. Ed. 2d 310, 120 S. Ct. 1418 (2000); United States v. A.D. Roe Co., 186 F.3d 717, 723-24 (6th Cir. 1999) (information received pursuant to a FOIA request is publicly disclosed); United States ex rel. Lamers v. City of Green Bay, 998 F. Supp. 971, 979-80 (E.D. Wis. 1998) (same), aff'd 168 F.3d 1013 (7th Cir. 1999). The FCA defines "original source" as someone "who has direct and independent knowledge of the information on which the allegations are based," 31 U.S.C. § 3730(e)(4)(B). This language excludes individuals who must rely upon information already in the possession of the government to adequately state their claim. Thus, Karvelas's argument for a relaxed pleading standard because the information he needs to plead with particularity is in the possession and control of the defendants cannot be answered by the court's suggestion that he could have obtained that information from the government prior to filing his complaint.

Nonetheless, we do not agree with Karvelas that "it is inherently inconsistent with the goals of the False Claims Act" to require a qui tam relator to specify "the time, dates, places, and identities" of the individuals involved in the fraud or "the specifics in the documents prepared and submitted by the defendant to obtain the funding" at the time that the complaint is filed and prior

to any additional discovery. n11 The False Claims Act requires a qui tam relator to serve on the "[a] copy of the complaint and written disclosure of substantially all material evidence and information the person possesses." 31 U.S.C. § 3730(b)(2). The complaint is filed in camera and remains under seal for 60 days during which time the government considers whether to intervene. Id. As a leading commentator has suggested, allowing a qui tam relator to amend his or her complaint after conducting further discovery would mean that "the government will have been compelled to decide whether or not to intervene absent complete information about the relator's cause of action." Boese, Civil False Claims and Qui Tam Actions § 4.04[C]. n12 Thus, allowing a relator to plead generally at the outset and amend the complaint at the 12(b)(6) stage after discovery would be at odds with the FCA's procedures for filing a qui tam action and its protections for the government (which is, of course, the real party in interest in a qui tam action).

Other courts have repeatedly refused to allow qui tam relators to rely on later discovery to comply with Rule 9(b)'s pleading requirements. See, e.g., Clausen, 290 F.3d at 1313 n.24. (noting that allowing a plaintiff "to learn the complaint's bare essentials through discovery . . . may needlessly harm a defendant['s] goodwill and reputation by bringing a suit that is, at best, missing some of its core underpinnings, and, at worst, [contains] baseless allegations used to extract settlements"); Russell, 193 F.3d at 308 (holding that "a special relaxing of Rule 9(b) is a qui tam plaintiff's ticket to the discovery process that the statute itself does not contemplate"). The reluctance of courts to permit qui tam relators to use discovery to meet the requirements

of Rule 9(b) reflects, in part, a concern that a qui tam plaintiff, who has suffered no injury in fact, may be particularly likely to file suit as "a pretext to uncover unknown wrongs." United States ex rel. Robinson v. Northrop Corp., 149 F.R.D. 142 (N.D. Ill. 1993) (noting Rule 9(b)'s discouragement of pre-textual claims in rejecting special 9(b) treatment of a qui tam plaintiff). n13 In light of the prevailing precedent and the procedures for filing and serving a qui tam complaint under 31 U.S.C. § 3730(b)(2) (providing for service on the government), we hold that a qui tam relator may not present general allegations in lieu of the details of actual false claims in the hope that such details will emerge through subsequent discovery. n14

4. The Compatability of Karvelas's Complaint with Rule 9(b)

Applying Rule 9(b) to Karvelas's complaint, the district court concluded that Karvelas failed to "state with specificity what the precise [false] claims were" or to "provide specifics regarding the documents submitted to HCFA to make the false claims." After carefully analyzing the sixteen "schemes" that Karvelas described in his 93-page complaint, the court found that he had failed in each to "allege violations of the False Claims Act sufficiently to meet his Rule 9(b) obligation." Similarly, the court held that the complaint failed to "provide reference to actual documentation" of the false claims that allegedly had been filed with the government.

As we have emphasized, liability under the False Claims Act requires a false claim. See Rivera, 55 F.3d at 709. Therefore, the defendant's presentation of false or fraudulent claims to the government is a central

element of every False Claims Act case. A health care provider's violation of government regulations or engagement in private fraudulent schemes does not impose liability under the FCA unless the provider submits false or fraudulent claims to the government for payment based on these wrongful activities. n15 See Clausen, 290 F.3d at 1311 ("Without the presentment of [a false or fraudulent] claim, while the practices of an entity that provides services to the Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the False Claims Act.")(emphasis in the original); United States ex rel. LaCorte v. SmithKline Beecham Clinical Labs., Inc., 2000 U.S. Dist. LEXIS 1938, No. 96-1380, 2000 WL 17838 (E.D. La., Jan. 10, 2000)(dismissing relator's claims with prejudice where relator described the general framework for alleged fraudulent schemes but failed to link the allegedly fraudulent practices to the submission of fraudulent claims). Underlying schemes and other wrongful activities that result in the submission of fraudulent claims are included in the "circumstances constituting fraud or mistake" that must be pled with particularity pursuant to Rule 9(b). However, such pleadings invariably are inadequate unless they are linked to allegations, stated with particularity, of the actual false claims submitted to the government that constitute the essential element of an FCA qui tam action.

As applied to the FCA, Rule 9(b)'s requirement that averments of fraud be stated with particularity - specifying the "time, place, and content" of the alleged false or fraudulent representations, means that a relator must provide details that identify particular false claims for payment that were submitted to the

government. n16 In a case such as this, details concerning the dates of the claims, the content of the forms or bills submitted, their identification numbers, the amount of money charged to the government, the particular goods or services for which the government was billed, the individuals involved in the billing, and the length of time between the alleged fraudulent practices and the submission of claims based on those practices are the types of information that may help a relator to state his or her claims with particularity. These details do not constitute a checklist of mandatory requirements that must be satisfied by each allegation included in a complaint. However, like the Eleventh Circuit, we believe that "some of this information for at least some of the claims must be pleaded in order to satisfy Rule 9(b)." Clausen, 290 F.3d at 1312 n.21. n17

In describing at considerable length the defendants' sixteen schemes to defraud the government, the complaint alleges that the defendants submitted false claims to the federal government, including cost reports that were falsely certified as complete, true, and correct. It states that the defendants wrongfully billed Medicare and Medicaid, and refers generally to false confirming orders and progress notes. However, the complaint never specifies the dates or content of any particular false or fraudulent claim allegedly submitted for reimbursement by Medicare or Medicaid. It provides no identification numbers or amounts charged in individual claims for specific tests, supplies, or services. It does not identify or describe the individuals involved in the improper billing or allege with particularity any certification of compliance with federal regulations in order to obtain payments. As Karvelas himself concedes in his brief to this court, his

complaint "did not set forth the specifics . . . of any one single cost report, or bill, or piece of paper that was sent to the Government to obtain funding." Nor does the complaint provide the source of information and factual basis for his conclusory allegations that the defendants submitted actual false or fraudulent claims to the government.

For example, in describing Scheme A, Karvelas alleges that the defendants "knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed" and "filed claims that were based on codes that the defendants knew would result in greater payments than what an appropriate code would have provided." Karvelas further claims that "staffing numbers in the Medicaid and Medicare filings were make believe throughout the entire hospital." However, the complaint does not specify the individuals who filed these claims, the dates on which any such claims were filed, the nature and content of any documents submitted, or the amount claimed from the government based on the particular medical items and services that were allegedly improperly provided or on the "make believe" staffing levels.

The complaint alleges in Scheme A that "from 1994 to 1997 the Hospital was certifying 12 respiratory therapists when in reality the hospital had only 7 full time respiratory therapists," yet it provides no details concerning the particular dates and content of the alleged certification, nor, assuming that the allegation was based on information and belief, does it set forth the source of that information or the facts on which the belief was founded. Karvelas also alludes to various

documents, referring to false "Respiratory Therapist time schedules for 1994 into 1997" and "documents signed under the penalty of perjury and false statement submitted to the United States Government [that] certified that there were 11.8 Respiratory Therapists during this period of time." However, he provides no particular details about the nature of these documents or the circumstances of their submission to the United States government.

With somewhat more specificity, Karvelas alleges in his discussion of Scheme B that the blood gas laboratory "performed approximately 21,000 arterial blood gas tests (ABG's) in the three year period beginning in June, 1994 through April, 1997 at $ 50.00 per test." However, while he states that the Hospital "billed Medicare and Medicaid for the costs of the testing on a large percentage of these patients with each bill certified to Medicare or Medicaid that the ABG laboratory had in fact complied with the CAP and CLIA standards, " Karvelas does not specify which of the 21,000 tests were billed to the government, supply any details about the particular bills and certifications submitted, or provide a factual basis for his allegation that the defendants falsely certified compliance with federal standards in order to secure Medicare or Medicaid benefits. This lack of particularity characterizes all of Karvelas's allegations concerning the submission of false claims to the federal government. n18

In summary, Karvelas alleges serious violations by the defendants of federal standards governing the provision of patient care. However, alleged violations of federal regulations are insufficient to support a claim

under the FCA. See United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996) ("Violations of laws, rules, or regulations alone do not create a cause of action under the FCA."); Clausen, 290 F.3d at 1311 ("If Rule 9(b) is to be adhered to, some indicia of reliability must be given in the complaint to support the allegation of an actual false claim for payment being made to the Government.") (emphasis in the original). While Karvelas does describe the procedures allegedly used by the hospital to submit false claims to the United States, the alleged existence of such procedures does not permit us to speculate that false claims were in fact submitted. See, e.g. United States ex rel. Walsh v. Eastman Kodak Co., 98 F. Supp. 2d 141, 147-48 (D. Mass. 2000) (dismissing complaint under Rule 9(b) where relator set out a methodology by which the defendants might have produced false claims without citing an actual false claim). As the district court correctly concluded, Karvelas's failure to identify with particularity any actual false claims that the defendants submitted to the government is, ultimately, fatal to his complaint. n19

D. Retaliation Claim

Karvelas argues that the district court improperly dismissed Count IV of his complaint for failure to state a claim of retaliation under 31 U.S.C. § 3730(h). n20 Congress added 31 U.S.C. § 3730(h) to the False Claims Act in 1986 to protect employees who pursue, investigate, or contribute to an action exposing fraud against the government. This section provides:Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of

employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. . . .31 U.S.C. § 3730(h). To prevail on a False Claims Act retaliation elaim, a plaintiff must show that 1) the employee's conduct was protected under the FCA; 2) the employer knew that the employee was engaged in such conduct; and 3) the employer discharged or discriminated against the employee because of his or her protected conduct. See, e.g, McKenzie v. BellSouth Telecomms., Inc., 219 F.3d 508, 514 (6th Cir. 2000); United States ex rel. Yesudian v. Howard Univ., 332 U.S. App. D.C. 56, 153 F.3d 731, 736 (D.C. Cir. 1998). Once the employee has established a prima facie case of retaliation, the burden shifts to the employer to prove that the employee would have been terminated or subjected to other adverse action even if he or she had not engaged in the protected conduct. Hutchins v. Wilentz, Goldman & Spitzer, 253 F.3d 176, 186 (3d Cir. 2001), cert. denied, 536 U.S. 906, 153 L. Ed. 2d 182, 122 S. Ct. 2360 (2002); Yesudian, 153 F.3d at 736 n.4 (quoting S. Rep. No. 99-345, at 34, reprinted in 1986 U.S.C.C.A.N. at 5300).

In the instant case, the district court determined that Karvelas's complaint did not allege facts sufficient to support the second element of his FCA retaliation claim (the employer's knowledge that he was engaging in protected conduct). On appeal, Karvelas argues that the district court erred in dismissing his retaliation claim because his complaint is "replete with allegations that at every stage Karvelas witnessed activities that could

lead to False Claims Act allegations, that he reported these activities, and that he was threatened and finally terminated for doing so." For the reasons set forth below, we affirm the decision of the district court, although on somewhat different grounds. n21

In order to satisfy the first element of a cause of action under 31 U.S.C. § 3730(h), a plaintiff must demonstrate that he or she engaged in activity protected under the FCA. This element of a retaliation claim does not require the plaintiff to have filed an FCA lawsuit or to have developed a winning claim at the time of the alleged retaliation. See Yesudian, 153 F.3d at 741. Rather, an employee's conduct is protected where it involves "acts done . . . in furtherance of" an FCA action. 31 U.S.C. § 3730(h). The statute's legislative history states that "protection should extend not only to actual qui tam litigants, but those who assist or testify for the litigant, as well as those who assist the Government in bringing a false claims action. Protected activity should therefore be interpreted broadly." S. Rep. No. 99-345, at 34, reprinted in U.S.C.C.A.N. at 5299.

Courts have adopted various standards for determining whether conduct is "in furtherance" of an action under the FCA. Some have said that a "plaintiff must be investigating matters which are calculated, or reasonably could lead, to a viable FCA action." Hopper, 91 F.3d at 1269; see Yesudian, 153 F.3d at 740. Some have found that activity is protected under § 3730(h) where litigation was "a distinct possibility" at the time that the employee made his or her disclosures to the employer. See, e.g., Childree v. UAP/GA AG Chem., Inc., 92 F.3d 1140, 1146 (11th Cir. 1996); Neal v.

Honeywell, Inc., 33 F.3d 860, 864 (7th Cir. 1994). Two circuits have drawn on Title VII's anti-retaliation provision, requiring the fact finder to determine that the plaintiff had a good faith and objectively reasonable belief that the defendant was committing fraud against the government. Wilkins v. St. Louis Hous. Auth., 314 F.3d 927, 933 (8th Cir. 2002); Moore v. Cal. Inst. of Tech. Jet Propulsion Lab., 275 F.3d 838, 845 (9th Cir. 2002). Although there is no particular magic in the word choice, we follow the approach of the Fifth Circuit and interpret "conduct in furtherance of an action under the FCA" as conduct that reasonably could lead to a viable FCA action. We think this standard is most consistent with the broad interpretation for protected activity under § 3730(h) urged by the legislative history, and we apply it here.

Karvelas argues that his complaint includes numerous "allegations to show that [he] witnessed and reported problems that could reasonably lead to False Claim Act cases." For example, he argues that he alleged engagement in protected activity when he claimed that:While still an employee of the Hospital, [he] pointed out to his superiors all the way up to the president, the inadequate staffing, inconsistent administration of treatment orders, the absence of blood gas quality control, and inappropriate documentation in the administration of care and treatment of patients throughout the Hospital, as well as the failure to meet regulatory standards which are required for reimbursement by Medicare and Medicaid.We do not agree with Karvelas that such activities constitute protected activity. It is true that Karvelas need not have known that his actions could lead to a qui tam suit under the FCA, or even that a

False Claims Act existed, in order to demonstrate that he engaged in protected conduct. See Yesudian, 153 F.3d at 741 (holding that "even an investigation conducted without contemplation - or knowledge of the legal possibility of - a False Claims Act suit can end up being 'in furtherance' of such an action"). However, conduct protected by the FCA is limited to activities that "reasonably could lead" to an FCA action; in other words, investigations, inquiries, testimonies or other activities that concern the employer's knowing submission of false or fraudulent claims for payment to the government. See id. at 740. Karvelas's statement that he reported his supervisors' destruction of incident reports of medical errors suggests a cover-up of regulatory failures but does not allege investigation or reporting of false or fraudulent claims knowingly submitted to the government. Although "correcting regulatory problems may be a laudable goal," it is "not actionable under the FCA in the absence of actual fraudulent conduct." Hopper, 91 F.3d at 1269; see McKenzie, 219 F.3d at 516 (noting that while internal reporting may be protected activity under the FCA, "the internal reports must allege fraud on the government"). Similarly, nearly all of Karvelas's statements concerning his alleged activities, the defendants' alleged knowledge of those activities, and the defendants' alleged retaliation against Karvelas for those activities suggest that Karvelas witnessed and reported problems concerning the hospital's alleged failure to comply with patient care standards. Such conduct, without more, does not constitute protected conduct under the FCA. n22

At two points in his complaint, however, Karvelas does suggest that he investigated and reported to his

employer problems with improper billing. First, he states:

112. The Relator John C. Karvelas also complained about directives from his immediate supervisor to complete patient evaluations even if the patients had been discharged or had died. These evaluations were billed at $ 150.00 each, which included inpatient and outpatient, and which were not reimbursable items, but yet were billed to Medicare and Medicaid. Mr. Karvelas' supervisor in the Respiratory Therapy department, Anthony Dichiara, threatened Respiratory Therapists with retaliation if they failed to participate in this illegal activity.He later claims that:

174. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. § 1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. Under 42 U.S.C. § 1320a-7a(a)(1)(A) the defendant Hospital filed claims that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided.

175. The Hospital acknowledged that it knew of the problem when Relator John C. Karvelas reported it internally, but still the Hospital failed to take corrective action.Although too vague to meet the Rule 9(b) pleading standards for a qui tam action, n23 these paragraphs allege that Karvelas was investigating and reporting the hospital's fraudulent billing practices rather than merely its noncompliance with state or

federal regulations. n24 The district court, however, found that these particular allegations failed to state an FCA retaliation claim because "the fact that [Karvelas] reported these problems does not mean that he gave notice to his employer that he was conducting an investigation of the hospital's billing practices as a precursor to a False Claims Act proceeding." We disagree with this analysis. n25

To meet the knowledge element of an FCA retaliation claim, "the whistleblower must show the employer had knowledge the employee engaged in 'protected activity.'" S. Rep. No. 99-345, reprinted in 1986 U.S.C.C.A.N. at 5300. In other words, the employer must be on notice that the employee is engaged in conduct that "reasonably could lead to a False Claims Act case." Yesudian, 153 F.3d at 742. However, just as the plaintiff is not required to know that his investigation reasonably could lead specifically to a False Claims Act action, the employer need not know that the employee has filed or plans to file a qui tam action, nor even necessarily be aware of the existence of the FCA. See Yesudian, 153 F.3d at 742. Instead, "the kind of knowledge the defendant must have mirrors the kind of activity in which the plaintiff must be engaged." Id. (explaining that "[a] plaintiff who need not even have heard of the FCA can hardly be required to inform his supervisor that he 'intends to utilize his allegations in furtherance of' an action under that Act."). What the employer must know is that the plaintiff is engaged in protected conduct, that is, investigation or other activity concerning false of fraudulent claims that the employer knowingly presented to the federal government. See, e.g., id. 742; Hopper, 91 F.3d at 1269. n26

Thus, to satisfy the knowledge element of § 3730(h), Karvelas must show that the defendants knew that he was investigating the Hospital's knowing presentation of false or fraudulent claims for payment to the government. Karvelas alleged, in paragraph 112 of his complaint, that he reported the hospital's knowing falsification of evaluations of dead or discharged patients and its illegal billing to Medicare and Medicaid for those evaluations. In paragraph 174, he stated that he reported internally that hospital officials "knowingly filed improper claims in that they presented claims for medical treatments they knew were not provided as claimed." Taking these allegations as true, it appears that Karvelas notified his employers about the results of his investigation concerning false claims for payment that the hospital knowingly submitted to the government. These representations did not simply report noncompliance with federal regulations, see Hopper, 91 F.3d at 1269, or complain of improper billing in accordance with Karvelas's job responsibilities, see Eberhardt, 167 F.3d at 867-68. n27 By notifying his employers about fraudulent claims for payment that the Hospital knowingly submitted to the government, Karvelas provided notice of protected conduct under the FCA. Therefore, we find that Karvelas has alleged facts sufficient to support an inference that he engaged in protected conduct under the FCA and that the defendants were put on notice of that conduct. See Carroll, 294 F.3d at 241 (explaining that a complaint will withstand a 12(b)(6) motion to dismiss if it "alleges facts sufficient to make out a cognizable claim").

However, in order to state a claim for retaliation, Karvelas must also allege that he was terminated because of his protected conduct. See S. Rep. No. 99-

345, at 35, reprinted in 1986 U.S.C.C.A.N. at 5300 (stating that the employee must show that "the retaliation was motivated, at least in part, by the employee's engaging in protected activity"). At the end of his complaint, Karvelas states generally the appropriate elements of a retaliation cause of action, claiming that the defendants retaliated against him because of his investigation of the hospital's FCA violations. n28 However, his complaint fails to allege facts sufficient to support this third element of his retaliation claim.

As we have observed, under the "notice" pleading standard of Federal Rule of Civil Procedure 8(a), a complaint should include "a short and plain statement of the claim showing that the pleader is entitled to relief," Fed. R. Civ. P. 8(a), and therefore need not include detailed pleading of the facts. However, while a complaint "need not include evidentiary detail," it must nonetheless "allege a factual predicate concrete enough to warrant further proceedings." DM Research, Inc. v. College of Am. Pathologists, 170 F.3d 53, 55 (1st Cir. 1999)(noting that "conclusory allegations in a complaint, if they stand alone, are a danger sign that the plaintiff is engaged in a fishing expedition"). Thus, even under the liberal pleading requirements of Rule 8(a), a plaintiff must "set forth factual allegations, either direct or inferential, respecting each material element necessary to sustain recovery under some actionable legal theory." Gooley v. Mobil Oil Corp., 851 F.2d 513, 514 (1st Cir. 1988). Simply parroting the language of a statutory cause of action, without providing some factual support, is not sufficient to state a claim. See Arruda, 310 F.3d at 18 (affirming that we do not credit claims made in a complaint if they are "bald assertions"

or "unsupportable conclusions.").

In his complaint, Karvelas alleges that his supervisor retaliated against him by falsely accusing him of improper conduct because he had told her boss about unsafe conditions and the lack of a back-up support system in the Respiratory Therapy Department. He further states that he was fired after returning from a meeting with senior management of the hospital, at which he reported "defective ABG testing run on a fetus" by another respiratory therapist. Karvelas "told his manager, Ms. Hyland-Miller, what he had done" and informed her about "the data he had collected, his visits with Drs. Sen and Lilly, and the failure of the Hospital to meet patient-care standards." He was fired on the spot. According to the complaint, Karvelas was subsequently informed by letter that he had been discharged because of "inappropriate behavior," including reporting "alleged unsafe conditions at the Hospital" to a member of a state senator's staff. However, as noted, investigations of allegedly unsafe conditions or noncompliance with patient care standards do not constitute protected conduct under the FCA. Nowhere in his complaint does Karvelas allege a factual predicate concrete enough to support his conclusory statement that he was retaliated against because of conduct protected under the FCA. Therefore, we conclude that the district court properly dismissed Count IV of Karvelas's complaint for failure to state a claim of retaliation under 31 U.S.C. § 3730(h).

E. Dismissal with Prejudice and Without Leave to Amend

Karvelas argues that even if his complaint failed to meet the pleading obligations of the Federal Rules of

Civil Procedure, the district court nonetheless erred when it dismissed his case with prejudice and without affording him an opportunity to amend his complaint. We disagree.

First, we reject Karvelas's argument that "a ruling on a 12(b)(6) motion is not a ruling on the merits; [but rather] only a non-merits ruling on the propriety of the pleadings." It is well settled in this circuit that dismissal for failure to state a claim pursuant to Fed. R. Civ. P. 12(b)(6) is a final decision on the merits. Acevedo-Villalobos v. Hernandez, 22 F.3d 384, 388 (1st Cir. 1994). As we have explained, "the dismissal of the complaint fits comfortably under the Supreme Court's definition of a 'final decision' . . . as one that 'ends the litigation on the merits and leaves nothing for the court to do but execute the judgment.'" Id. (quoting Firestone Tire & Rubber Co. v. Risjord, 449 U.S. 368, 373-74, 66 L. Ed. 2d 571, 101 S. Ct. 669 (1981)). Moreover, in the absence of a clear statement to the contrary, a dismissal pursuant to Fed. R. Civ. P. 12(b)(6) is presumed to be with prejudice. See Andrews-Clarke v. Lucent Tech., Inc., 157 F. Supp. 2d 93, 99 (D. Mass 2001)("A dismissal for failure to state a claim is a dismissal on the merits . . . . This type of dismissal, presumed to be with prejudice unless the order explicitly states otherwise, has a claim preclusive effect."); c.f. Mirpuri v. ACT Mfg., Inc., 212 F.3d 624, 628 (1st Cir. 2000)("In this circuit, the phrase 'without prejudice,' when attached to a dismissal order, is . . . to be read . . . as a signification that the judgment does not preclude a subsequent lawsuit on the same cause of action either in the rendering court or in some other forum."). Thus, in dismissing with prejudice Karvelas's complaint under Rule 12(b)(6), the district court did not depart from established precedent but

simply stated explicitly what in any event would have been presumed.

Similarly, the district court did not err by failing to invite Karvelas to amend his complaint prior to dismissing the case with prejudice. Although the denial of a motion to amend is reviewed only for abuse of discretion, "district courts do not customarily aim to defeat valid claims." E. Food Servs., Inc. v. Pontifical Catholic Univ. Servs. Ass'n, 357 F.3d 1, 2004 U.S. App. LEXIS 764, No. 02-2391, at 14-15 (1st Cir. Jan. 20, 2004). Some courts have, in their discretion, allowed relators to amend FCA complaints to cure a lack of particularity. See, e.g., United States ex rel. McCoy v. Calif. Med. Rev., Inc., 723 F. Supp. 1363, 1366 (N.D. Cal. 1989).

In this case, however, Karvelas never filed a motion to amend pursuant to Fed. R. Civ. P. 15(a), which provides for amendments as of right in the absence of a responsive pleading. n29 Therefore, the only issue before us is whether the district court erred in failing sua sponte to provide Karvelas an opportunity to amend before dismissing his complaint with prejudice. n30 Absent exceptional circumstances, a district court has no obligation to invite a plaintiff to amend his or her complaint when the plaintiff has not sought such amendment. See Emerito Estrada Rivera-Isuzu de P.R. Inc. v. Consumers Union, 233 F.3d 24, 30 (1st Cir. 2000) (holding that district court did not commit error by "failing to invite Emerito to replead" where "despite its awareness that [the defendant] had called for dismissal [for failure to state a claim based on deficient pleadings], Emerito never amended its complaint as of right . . . nor did it formally ask the district court after

judgment to permit such an amendment")(emphasis in the original); see also Wagner v. Daewoo Heavy Indus. Am. Corp., 314 F.3d 541, 542 (11th Cir. 2002)("A district court is not required to grant a plaintiff leave to amend his complaint sua sponte when the plaintiff, who is represented by counsel, never filed a motion to amend nor requested leave to amend before the district court."). In this case, Karvelas chose not to file a motion to amend his complaint at any stage of the litigation. Instead, he stood upon his 93-page complaint, even after the defendants filed a 12(b)(6) motion to dismiss that focused on deficiencies in the pleadings. n31 Indeed, the district court had already afforded Karvelas a generous opportunity to sharpen his pleadings when it did not dismiss with prejudice the plaintiff's first FCA retaliation complaint against the defendants. Under these circumstances, the district court did not err by failing sua sponte to provide Karvelas an opportunity to amend his complaint before dismissing the case with prejudice. n32

III.

Karvelas filed in the district court a 93-page complaint alleging that the defendants violated the False Claims Act and describing sixteen fraudulent "schemes" in which they allegedly participated. The complaint includes some detail about the nature of these schemes and about the defendants' alleged failure to comply with patient care standards. However, in the 93 pages of this lengthy document, we find no allegation, pled with adequate specificity, of a false claim for payment that was actually presented to the government. See Clausen, 290 F.3d at 1312 (upholding dismissal of FCA qui tam complaint where "nowhere in the blur of facts

and documents assembled by [the relator] regarding six alleged testing schemes [could] one find any allegation, stated with particularity, of a false claim actually being submitted to the Government"). The law is clear that the False Claims Act attaches liability to the submission of false claims for payment, not to the underlying fraudulent activity or other wrongful conduct on which those claims were based. See Rivera, 55 F.3d at 709. The district court correctly recognized this difference when it dismissed Karvelas's complaint.

Affirmed.

FOOTNOTES

* Of the District of New Hampshire, sitting by designation.

n1 The Health Care Financing Administration became the Centers for Medicare and Medicaid Services ("CMS") on June 1, 2001.

n2 This was the second federal lawsuit that Karvelas has initiated against the defendants in connection with their alleged fraudulent activities. His first complaint, which was filed in May 2000, alleged essentially the same retaliation claim pleaded in this case, as well as various state law claims. The district court dismissed the action, without prejudice, for failure to state a claim. Karvelas v. Melrose-Wakefield Hospital, Civ. No. 00-10991 (D. Mass. May 5, 2000).

n3 The court noted that the judgment was without prejudice to any claim that the federal government could have raised in the action, explaining that the

government "remains free to exercise its discretion and judgment regarding its own litigation posture with respect to matters related to or suggested by claims the plaintiff had unsuccessfully presented to this court."

n4 The district court also dismissed Count V of Karvelas's complaint alleging violations of the Racketeer Influenced and Corrupt Organization (RICO) statute, 18 U.S.C. § 1961, et seq. Karvelas does not appeal the dismissal of this claim.

n5 "'Qui tam' is an abbreviation for qui tam pro domino rege quam pro seipso, which literally means 'he who as much for the king as for himself.'" United States ex rel. S. Prawer & Co. v. Fleet Bank, 24 F.3d 320, 324 n.7 (1st Cir. 1994) (citation omitted). Qui tam provisions first became popular in thirteenth century England. They permitted private individuals to bring suit on behalf of the King and served as a supplement to official law enforcement. Id.

n6 The historical background of the False Claims Act and its subsequent amendments has been described in detail by this and other courts. See, e.g., Prawer, 24 F.3d at 324-26; United States ex rel. Springfield Terminal Ry Co. v. Quinn, 304 U.S. App. D.C. 347, 14 F.3d 645, 646, 649-51 (D.C. Cir. 1994); United States ex rel. Williams v. NEC Corp., 931 F.2d 1493, 1496-98 (11th Cir. 1991); United States ex rel. Stinson, Lyons, Gerlin & Bustamante v. Prudential Ins. Co., 944 F.2d 1149, 1153-54 (3d Cir. 1991).

n7 A "relator" is "[a] party in interest who is permitted to institute a proceeding in the name of the People or the Attorney General when the right to sue resides

solely in that official." Black's Law Dictionary 1289 (6th ed. 1990).

n8 In Langadinos v. American Airlines, Inc., 199 F.3d 68, 73 & n.8 (1st Cir. 2000), we noted that while "a plaintiff can make allegations either on the basis of personal knowledge or on 'information and belief,'" there is an "exception . . . in cases where the tougher pleading standards of Fed. R. Civ. P. 9(b) replace the more liberal requirements of Fed. R. Civ. P. 8." To the extent that this language suggests that information and belief pleading is impermissible under Rule 9(b), it is dicta and it is inaccurate. Information and belief pleading is permissible, subject to Rule 9(b)'s particularity requirement and the additional requirement that pleadings on information and belief set forth the facts on which that belief is founded.

n9 On the other hand, prior to the enactment of the Private Securities Litigation Reform Act, we strictly applied Rule 9(b)'s pleading requirements in securities fraud cases even when the fraud related to matters peculiarly within the knowledge of the defendants because of our concern that "a plaintiff with a largely groundless claim will bring a suit and conduct extensive discovery in the hopes of obtaining an increased settlement." Id. at 288; see also Hayduk v. Lanna, 775 F.2d 441, 443 (1st Cir. 1985) (in a securities fraud case, Rule 9(b) "does not permit a complainant to file suit first, and subsequently to search for a cause of action")(citation and quotation marks omitted).

n10 For the rare cases, see, for example, Wilkins ex rel. United States v. Ohio, 885 F. Supp. 1055 (S.D. Ohio 1995)(holding that relator's failure to meet the

particularity requirements of Rule 9(b) did not bar his claim where the relator was a former employee of the defendants and lacked access to records and documents in the possession of the defendants that contained information necessary to plead with particularity); United States ex rel. Kozhukh v. Constellation Tech. Corp., 64 F. Supp. 2d 1239 (M.D. Fla. 1999)(same).

n11 Contrary to Karvelas's suggestion on appeal, the district court did not hold that Rule 9(b) required the production of actual documentation. The court's occasional references to the absence of actual documents do not suggest that the court "refused to consider any documents referred to in the complaint because Karvelas failed to produce them." Nor did the district court's "insistence that the qui tam relator has to plead fraud with particularity mean [] that the relator must plead the particulars of each document to which reference is made." Rather, as the district court correctly recognized, Karvelas was required to describe with particularity some of the documents containing false claims for payment that the defendants allegedly submitted to the United States.

n12 Although the government may intervene later in the litigation, "such intervention is not mandatory. . . . Moreover, while it may intervene, the government will no longer have an opportunity to conduct a confidential and unhurried investigation of the new claims in the amended complaint." Id. at § 4.04[C].

n13 This requirement also applies where the complaint refers to "a regularly-filed document prepared by the defendants." We disagree with Karvelas that such documents are excepted from Rule 9(b)'s heightened pleading standard.

n14 In a final variant of his claim for relaxation, Karvelas asserts that the district court should have applied a relaxed Rule 9(b) standard because the defendants' alleged fraudulent schemes were complex and occurred over a period of several years. While we have not adopted such an exception to Rule 9(b)'s pleading requirements, a few courts have found that a relaxed standard may apply to FCA qui tam complaints where the alleged conduct took place over a long period of time or involved numerous occurrences. See, e.g., United States ex rel. Butler v. Magellan Health Servs., Inc., 74 F. Supp. 2d 1201, 1215 (M.D. Fla. 1999); United States ex rel. Thompson v. Columbia/HCA Healthcare, 20 F. Supp. 2d 1017, 1039 (S.D. Tex. 1998). Although we do not preclude the possibility of such an exception in a future case, we do not think that three years presents an exceptionally long period of time. Nor do we find any basis in the history or requirements of the FCA, or in most of the precedents, for relieving Karvelas of his burden of pleading fraud with particularity because he chose to allege sixteen complex schemes. See Yuhasz, 341 F.3d at 564 ("[A] plaintiff should not be able to avoid the specificity requirements of Rule 9(b) by relying upon the complexity of the edifice which he created")(citation and internal quotation marks omitted).

n15 A number of courts have also found FCA violations where a defendant falsely certifies compliance with certain conditions required as a prerequisite for a government benefit or payment in order to induce that benefit. See, e.g., Thompson, 125 F.3d at 902. In such cases, false certification for the purpose of receiving a payment or benefit becomes the practical equivalent of a statutory false claim.

n16 In the FCA context, the concept of "place" holds less relevance for allegations about fraudulent bills or other claims allegedly submitted to the government. It remains an important detail in pleadings concerning the underlying tests, schemes, or other conduct that is linked to the submission of false claims.

n17 In a related context, we held that courts will allow private securities fraud cases "to advance past the pleadings stage when some questions remain unanswered, provided the complaint as a whole is sufficiently particular to pass muster under the PSLRA." Cabletron, 311 F.3d at 32; see Greebel v. FTP Software, Inc., 194 F.3d 185, 193 (1st Cir. 1999)(stating that the pleading requirements of the Private Securities Litigation Reform Act (PSLRA) "embody in the act itself at least the standards of Rule 9(b)"). We found that Cabletron's complaint satisfied the PSLRA's particularity requirements because "the fraud allegations advanced in [the] complaint, with their consistent details provided from at least half a dozen different sources across various alleged schemes, reinforce each other and suggest reliability of the information reported." Cabletron, 311 F.3d at 33. By contrast, as we discuss below, Karvelas's complaint does not allege the particulars of any of his allegations concerning the presentation of false claims to the government, and therefore, considered as a whole, the complaint does not meet the particularity requirements of 9(b). See Greebel, 194 F.3d at 204 (finding that the absence of any of a number of enumerated "basic details" describing alleged PSLRA violations was "indicative of the excessive generality of these allegations").

n18 Indeed, with one exception, Karvelas's complaint does not specify which of the particular violations of patient care standards that Karvelas witnessed involved Medicare or Medicaid patients. That exception involves the allegation that hospital administrators instructed him and others to falsify test results so that a trustee/patient of the hospital would qualify for Medicare payment for home oxygen. He further states that on January 26, 1997, the trustee/patient admitted to him that the results of the test were falsified. However, while this allegation provides specific details about the purported fraudulent activity, it does not identify or describe the false claims that were allegedly submitted to Medicare in connection with the trustee's treatment.

n19 Because we conclude that Karvelas has not stated with specificity allegations of actual false claims submitted to the government, we need not consider the adequacy of his pleadings concerning the defendants' alleged "schemes" or failure to comply with patient care standards.

n20 The defendants urged the district court to reject Karvelas's retaliation claim on res judicata grounds because the court had previously dismissed a similar claim filed by Karvelas against the defendants for failure to state a claim upon which relief could be granted. See Karvelas v. Melrose-Wakefield Hospital, Civ. No. 00-10991 (D. Mass. May 5, 2000). Although it acknowledged that there is circuit authority for the proposition that a Rule 12(b)(6) dismissal has res judicata effect, the court declined to dismiss the case on that ground because its order of dismissal in the earlier case, entered without prejudice, had "noted that

plaintiff's False Claims Act litigation was in its early states."

n21 In his complaint, Karvelas states that "throughout [his] employment at Melrose-Wakefield, he complained to management about deficiencies in the care and about the activities hereinbefore related within his department and throughout the Hospital." He explains in his opposition to the defendants' motion to dismiss that the phrase, "hereinbefore related," includes every allegation pled in the prior paragraphs of his complaint. We agree with the district court that "it is not sufficient to plead in this paragraph that '[Karvelas] complained to management about' each activity pled in the previous 458 paragraphs" and, like the district court, we consider only those allegations that concern Karvelas's interactions and communications with his employers and activities that were the subject of those communications.

n22 Where an employee has not engaged in conduct protected under the FCA, he cannot meet the second and third elements of an FCA retaliation claim, as those depend upon the first. See, e.g., Yesudian, 153 F.3d at 743 (explaining that "grumbling to the employer about job dissatisfaction or regulatory violations" does not demonstrate that the plaintiff's employer was aware of the protected activity, "just as it does not constitute protected activity in the first place").

n23 A retaliation claim under 31 U.S.C. § 3730(h) does not require a showing of fraud and therefore need not meet the heightened pleading requirements of Rule 9(b). See, e.g., United States ex rel. Barrett v. Columbia/HCA Health Care Corp., 251 F. Supp. 2d 28,

38 (D.D.C. 2003) ("While [plaintiffs'] complaint inartfully and inadequately pleads the FCA causes of action . . ., that does not dictate a 12(b)(6) dismissal of the retaliation discharge based on the well-pleaded facts underlying those causes of action.").

n24 As we are required to make all reasonable inferences in favor of the plaintiff in considering a 12(b)(6) motion, we construe paragraph 112 to allege that Karvelas complained about the fraudulent billing of unnecessary patient evaluations as well as about the evaluations themselves.

n25 We do not read the language of the district court to suggest that Karvelas was required to notify the Hospital that his investigation was in fact a "precursor to" an FCA case. For the reasons we explain, such a holding would be incorrect as a matter of law. As the district court itself recognized, a "defendant need not know, or be advised, that [the false or fraudulent claims investigated by the employee] would violate the False Claims Act itself." Yesudian, 153 F.3d at 742. n26 Some courts have held that employees who investigate government billings or payments as part of their job duties must "make it clear that the employee's actions go beyond the assigned task" in order to demonstrate that they were engaged in protected conduct and their employers were on notice of that conduct. United States ex rel. Eberhardt v. Integ. Design & Constr., Inc., 167 F.3d 861, 868 (4th Cir. 1999); Brandon v. Anesthesia & Pain Mgmt. Assocs., 277 F.3d 936, 945 (7th Cir. 2002) (stating that where plaintiff's job responsibilities included ensuring that hospital billing practices complied with Medicare regulations, "the fact that Brandon was alerting his supervisors to

the possibility of their non-compliance with the rules would not necessarily put them on notice that he was planning to take a far more aggressive step and bring a qui tam action against them or report their conduct to the government"). Because Karvelas's job duties did not involve investigating government payments or billings, he need not meet the heightened requirements for employees whose job descriptions do include such responsibilities in order to establish a § 3730(h) retaliation claim.

n27 Moreover, Karvelas alleges that he told his employers about the submission of claims that were in fact fraudulent, in contrast to the claims reported by the employee in Luckey v. Baxter, 183 F.3d 730, 732 (7th Cir. 1999)(noting that "only in Humpty Dumpty's world of word games would anyone apply the label 'fraud' to the kind of representations Baxter made"). Therefore, we disagree with the district court that Luckey is controlling here.

n28 The complaint states that "Defendant Melrose-Wakefield discharged John Karvelas in retaliation for his investigation of the defendants' violations of its Government contracts under Medicaid and Medicare and its False Claims Act violations." Applying the language of § 3730(h), it further claims that "Relator John Karvelas was discriminated against in his termination by Defendant Melrose-Wakefield Hospital by and through its officers, agents, and employees, because of lawful acts done by him in the furtherance of an action under the False Claims Act, including his participation in the investigation of an action under the False Claims Act and his reporting to the United States Government the fraudulent actions of the defendants."

n29 A motion to dismiss is not considered a responsive pleading. See Leonard v. Parry, 219 F.3d 25, 30 (1st Cir. 2000).

n30 The defendants argue that because Karvelas never moved for leave to amend, the issue of whether the district court erred by denying such a request is not before this court. We agree. See Dartmouth Rev. v. Dartmouth College, 889 F.2d 13, 23 (1st Cir. 1989)(holding that "the question of whether it might have been error for the court to have denied leave to amend is not before us, because plaintiffs never requested it")(quotation marks omitted). However, Karvelas does not argue that the district court erred in denying a request to amend, but rather that it erred by failing sua sponte to provide Karvelas an opportunity to amend, or notice that his pleadings were deficient, before dismissing the case with prejudice. This question is properly before us. Moreover, we do not agree with the defendants that Karvelas waived this argument because he did not seek amendment after the dismissal by moving for reconsideration or relief from the judgment. A dismissal with prejudice is a final judgment that "slams the door shut on the possibility of future amendments to the complaint" unless the judgment is set aside or vacated pursuant to Rule 59 or Rule 60. Mirpuri v. ACT Mfg., Inc., 212 F.3d 624, 629 (1st Cir. 2000). Motions for post-judgment relief and direct appeal thus provide two separate avenues through which a plaintiff may challenge the dismissal of a complaint with prejudice and without leave to amend. See Acevedo-Villalobos, 22 F.3d at 389 ("Where, as here, a complaint is dismissed without leave to amend, the plaintiff can appeal the judgment or, alternatively, seek leave to amend under Rule 15(a) after having the

judgment reopened under either Rule 59 or 60.").

n31 As the defendants point out, the government's decision not to intervene in the action also suggested that Karvelas's pleadings of fraud were potentially inadequate.

n32 We conclude that the district court did not err in failing sua sponte to provide Karvelas an opportunity to amend without referring to a specific standard of review. We do that because, frankly, our cases seem inconsistent in their choice of the standard of review applicable to such cases, reviewing for abuse of discretion, see Romani, 929 F.2d at 878; plain error, see Emerito, 233 F.3d at 30; and the interest of justice, see Dartmouth Rev. 889 F.2d at 23. We need not resolve this issue here. Under any standard of review, the district court did not err in dismissing Karvelas's complaint with prejudice and without granting leave to amend.

United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 2003 WL 21228801 (D. Mass. 2003)
RICO Bus.Disp.Guide 10,483

United States District Court,
D. Massachusetts.
UNITED STATES OF AMERICA ex rel. John C. Karvelas, Plaintiff,
v.
MELROSE-WAKEFIELD HOSPITAL, Melrose-Wakefield Healthcare Corporation, and Hallmark Health System, Inc., Defendants.

No. Civ.A. 01-10583-DPW.
May 21, 2003.

Employee, as relator, brought qui tam action against employer hospital alleging violations of False Claims Act (FCA) and Racketeer Influenced and Corrupt Organizations Act (RICO). On hospital's motion to dismiss with prejudice, the District Court, Woodlock, J., held that: (1) relator's FCA complaint did not satisfy requirements of pleading special matters rule; (2) hospital did not violate the anti-retaliation provision of FCA; and (3) employee lacked standing to bring claim under RICO against employer.

Motion granted.

West Headnotes

[1] KeyCite Notes

170A Federal Civil Procedure
170AVII Pleadings and Motions

170AVII(A) Pleadings in General
170Ak633 Certainty, Definiteness and Particularity
170Ak636 k. Fraud, Mistake and Condition of Mind. Most Cited Cases

393 United States KeyCite Notes
393VIII Claims Against United States
393k120 Making or Presentation of False Claims and Other Offenses Relating to Claims
393k122 k. Penalties and Actions Therefor. Most Cited Cases

Relator's lengthy False Claims Act (FCA) complaint did not satisfy requirements of pleading special matters rule for failure to allege fraud with sufficient particularity and for failure to provide reference to actual documentation, although relator alleged several "schemes" in which defendant participated. 31 U.S.C.A. § 3729 et seq; Fed.Rules Civ.Proc.Rule 9(b), 28 U.S.C.A.

[3] KeyCite Notes

319H Racketeer Influenced and Corrupt Organizations
319HI Federal Regulation
319HI(B) Civil Remedies and Proceedings
319Hk56 Persons Entitled to Sue or Recover
319Hk62 k. Causal Relationship; Direct or Indirect Injury. Most Cited Cases

Employee lacked standing to bring claim under Racketeer Influenced and Corrupt Organizations Act (RICO) against employer, since nexus between alleged RICO violations asserted by employee and any injuries to him was insufficiently close to say that one

proximately caused the other; although employee alleged that he was fired because of actions he took to report and to stop allegedly illegal schemes, employee was not defrauded party and he was not target of any of acts pleaded as "predicate acts" in RICO claim. 18 U.S.C.A. § 1962.

MEMORANDUM AND ORDER

WOODLOCK, J.

*1 Plaintiff John C. Karvelas ("the "Relator") initiated this qui tam action alleging violations of the False Claims Act, 31 U.S.C. §§ 3729 et seq., and Racketeer Influence and Corrupt Organization (RICO) statute, 18 U.S.C. § 1961, et seq., occurring at Melrose-Wakefield Hospital. The United States declined to join the action. Before me is defendants' 12(b)(6) motion to dismiss for failure to state a claim upon which relief can be granted.

I. BACKGROUND

Karvelas was employed as a Respiratory Therapist at the defendant Melrose- Wakefield Hospital, located in Melrose, Massachusetts, in 1982 and worked there for 15 years until January 27, 1997. [FN1]

FN1. Karvelas also worked at other hospitals owned by defendant Hallmark Health System, Inc. "for five months in 1992," "in 1990," and "between 1982 and 1983."

Karvelas alleges that during his employment at the hospital he "pointed out to his superiors, all the way up to the president, the inadequate staffing, inconsistent

administration of treatment orders, the absence of blood gas quality control, and inappropriate documentation in the administration of care and treatment of patients throughout the Hospital, as well as the failure to meet regulatory standards which are required for reimbursement by Medicare and Medicaid. He repeatedly pointed out to Hospital personnel that the Hospital was not in compliance with regulatory standards and that they were providing substandard care." [Complaint at ¶ 106.]

Specifically, Karvelas alleges that, on September 9, 1996, he notified the Vice President of Human Resources, Richard Kenny, that the hospital should take "corrective action" regarding defective "arterial blood gas (ABG) testing machinery, [FN2] about understaffing and patient neglect." Karvelas also claims he informed Kenny his "supervisors had destroyed incident reports regarding medical errors." [Complaint at ¶ 108, ¶ 110, see ¶ 171.] He complained to Kenny that he had been directed by his supervisor to complete patient evaluations, which were improperly billed to Medicare and Medicaid, and had been threatened with "retaliation" if they "failed to participate in this illegal activity." [Complaint at ¶ 112.] [FN3]

FN2. Karvelas charges that the hospital "falsely certified the satisfactory completion of the ABG tests required under the C.F.R. to gain Medicare and Medicaid funding." [Complaint ¶¶ 164-70.] He does not say that he informed hospital staff that the machinery was falsely certified to be satisfactory.

FN3. Karvelas alleges later in the complaint that the

> hospital filed claims with Medicare "that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided." [Complaint ¶ 174.] According to Karvelas, the hospital acknowledged that it knew of this problem "back in September 1996 when the Relator John C. Karvelas reported it internally, but still the Hospital failed to take corrective action." [Complaint ¶ 175.]

Later that month, Karvelas went to speak with Dr. William Lilly, the director of the laboratory, after Karvelas perceived that no corrective actions were taken following his meeting with Kenny. [Complaint ¶ 172.] [FN4]

FN4. In paragraph 113 of the complaint, Karvelas states that he was "directed to go see" Dr. Lilly.

Karvelas alleges that, in October 1996, Brenda Hyland-Miller accused him of improperly dispensing medication and not doing a patient evaluation, "in order to retaliate against Karvelas for reporting to her boss that there was no back up system in place." [Complaint ¶ 114.]

The plaintiff claims that because the hospital failed to take "corrective action" about the conditions he had brought to Kenny's attention, he went to see Dr. Ronald Sen on January 27, 1997, and provided him with Quality Control Logs relating to blood gas testing. [Complaint at ¶ 116.] [FN5] Dr. Sen asked Karvelas "to immediately speak to Dr. Sen's superior, Dr. Lilly. Upon examining the logs, Dr. Lilly stated that he could not believe that one of the Relator's supervisors 'had

been lying to him all that time." ' [Complaint at ¶ 116.]

FN5. Later in the complaint, Karvelas states that he Karvelas also went to speak with Dr. Sen on January 27, 1997 "because of an incident that occurred on January 22, 1997. [Complaint ¶¶ 172-73 .] Karvelas was concerned because "[n]o controls were run prior to running" an ABG test on "a fetus while in the mother's womb." According to Karvelas, a review of "the other method of determining fetal distress found that in fact the baby was in distress." [Complaint ¶ 173.] Karvelas found this event "disturbing" and "indicative of failure to act" by the hospital, so he went to speak with Dr. Sen and then Dr. Lilly. [Complaint ¶ 173.]

*2 Then, according to Karvelas, he returned to the Respiratory Therapy Department after meeting with Dr. Sen and Dr. Lilly. Upon his return, Hyland- Miller asked where he had been. [Complaint ¶ 119.] Karvelas described his data and his visits with the doctors, "and the failure of the Hospital to meet patient-care standards." According to Karvelas, Hyland-Miller then "pushed the Relator against the wall and said, 'I know everything you're doing. That's it. You are gone. You are out of here. You're terminated. You no longer work here." ' [Complaint ¶ 119.] Hyland-Miller and Kenny signed a letter dated January 28, 1997 that told the Relator "he had been discharged because of 'inappropriate behavior ... for example, on January 7, 1997, the Hospital learned from a member of a state senator's staff that you had reportedly alleged unsafe conditions at the Hospital." ' [Complaint ¶ 121.] [FN6]

FN6. At some point during Karvelas's employment, the following event also allegedly occurred: "The Relator objected to the directives from his immediate supervisor, Anthony Dichiara, to complete patient evaluations even if the patients had been discharged or had died. These evaluations were billed at $150.00 each, and they included inpatient and outpatient, which were not reimbursable items, but yet were billed. Dichiara threatened the Relator and the other Respiratory Therapists with retaliation if they failed to participate in this illegal activity." [Complaint ¶ 262.]

Karvelas first filed a retaliation, wrongful discharge and defamation action against the defendants in this matter together with Quinlan, Kenny and Hyland-Miller. Karvelas v. Melrose-Wakefield Hospital, Civ. No. 00-10991 (D. Mass. May 5, 2000) ("Karvelas I"). Although the complaint in Karvelas I contained a claim alleging employment termination as retaliation for plaintiff's False Claims Act activities, the case was not itself a False Claim Action qui tam proceeding; as counsel for the plaintiff noted at a scheduling conference on September 20, 2000, none had then been filed. I dismissed Karvelas I by memorandum and Order dated December 19, 2000. I found that "the plaintiff's broadly stated and conclusory allegations concerning False Claims Act retaliation do not adequately present a cognizable claim." Id. at 2. Because the False Claims Act retaliation claim I dismissed was the only claim providing federal jurisdiction and the case was in its beginning stages, I declined to exercise supplemented jurisdiction under 18 U.S.C. § 1367 over the remaining state law claims.

Karvelas then filed the present complaint on April 6, 2001, as a False Claims Act qui tam action repleading as part of the allegations the False Claims Act retaliation I had previously dismissed. On May 3, 2002, the federal government gave notice of its decision not to intervene in the case. Upon the notice of declination from the government, I ordered the Complaint unsealed and authorized service on the defendants. In a "Statement of Interest Regarding Defendants' Motion to Dismiss," the government, while taking no position on the merits of the motion to dismiss, has filed a request that any dismissal of plaintiff's action be made without prejudice to later pursuit of claims by the government should it choose to do so.

II. DISCUSSION

A. Standard

A complaint may be dismissed under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted "only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations." Gorski v. New Hampshire Dep't of Corrections, 290 F.3d 466, 473 (1st Cir.2002). In ruling on a motion to dismiss, a court must accept as true the factual allegations of the complaint, and all reasonable inferences must be drawn in favor of the plaintiff. Moss v. Camp Pemigewassett, Inc., 312 F.3d 503, 506 (1st Cir.2003).

*3 Both the defendants in moving to dismiss and the plaintiff in opposition direct my attention to materials beyond the complaint. Along with their motion, the defendants submitted an affidavit of Richard G. Kenny,

Senior Vice President of Human Resources for Hallmark Health System, Inc., d/b/a Melrose-Wakefield Hospital. The Kenny affidavit recites the course of the dispute between Karvelas and the defendants and attaches various correspondence and papers filed in proceedings in other fora. In addition, attached to the defendant's memorandum in support of its motion to dismiss are several exhibits relating to Karvelas I and a notice of docket entry in the Supreme Judicial Court for Suffolk County regarding the dissolution of the defendant Melrose- Wakefield Healthcare Corporation on November 22, 2000.

In opposition to defendants' motion to dismiss, the plaintiff seeks to draw support from an affidavit attached to his opposition memorandum, as well as a "Chart Describing the Sixteen Schemes Involving Medicare Fraud," and two exhibits outlining specificity plaintiff's "arguments" in schemes A--P.

On a Rule 12(b)(6) motion to dismiss, a court will generally not consider materials beyond the complaint. See McInnis-Misenor v.. Maine Medical Ctr., 319 F.3d 63, 67 (1st Cir.2003); Gonzalez v.. United States, 284 F.3d 281, 288 (1st Cir.2002). The Federal Rules of Civil Procedure provide that, should "matters outside the pleading" be presented to and not excluded by the court, a 12(b)(6) motion to dismiss "shall be treated as one for summary judgment and disposed of as provided in Rule 56." Fed. R. Civ. P. 12(b)(6). The First Circuit has taken a "functional" rather than "mechanical" approach to Rule 12(b)(6) conversion, holding that a motion to dismiss "is not automatically transformed into a motion for summary judgment simply because matters outside the pleadings are filed with, and not

expressly rejected by, the district court," as long as the district court "chooses to ignore the supplementary material and determines the motion under the Rule 12(b)(6) standard." Garita Hotel Ltd. Partnership v. Ponce Federal Bank, 958 F.2d 15, 18 (1st Cir.1992); see also Stein v. Royal Bank of Canada, 239 F.3d 289, 392 (1st Cir.2001); Clorox Co. Puerto Rico v. Proctor & Gamble Commercial Co., 228 F.3d 24, 31 (1st Cir.2000); Rodriquez v. Fullerton Tires Corp., 115 F.3d 81, 83 (1st Cir.1997). Here, in ruling on defendants' motion to dismiss, I will only consider the plaintiff's complaint as further explicated in plaintiff's submissions in connection with his opposition, although I have taken judicial notice of actions reflected in the files of this court regarding Karvelas I.

B. Discussion

1. Counts I-III: False Claims Act Substantive Claims

[1] The defendants contend that the claims brought under the False Claims Act do not satisfy the requirements of Fed. R. Civ. P. 9(b). In support of their motion to dismiss, the defendants point to the fact that Karvelas identifies no specific actual claim that was submitted by the defendants in violation of the False Claims Act.

*4 A complaint alleging violations of the False Claims Act "must fulfill the requirements of Rule 9(b)." United States ex rel. Russell, Epic Healthcare Mgmt. Group, 193 F.3d 304, 308 (5th Cir.1999); United States ex rel. Franklin v. Parke-Davis, 147 F. Supp. 2d 39, 46 (D. Mass.2001); United States Clausen v. Laboratory Corp.

of America, Inc., 198 F.R.D. 560, 562 (N.D. Ga.2000); United States ex rel. Roby v. Boeing Co., 184 F.R.D. 107, 109 (S.D. Ohio 1998).

Rule 9(b) requires that a complaint set forth allegations of fraud with particularity, including the time, place, specific content of the false representations, and the identities of the parties participating in the fraud. See Franklin, 147 F. Supp. 2d at 46; Roby, 184 F.R.D. at 109-10; see also Russell, 193 F.3d at 308. See generally Boston & Maine Corp. v. Town of Hampton, 987 F.2d 855 (1st Cir.1993). At a minimum, the complaint must provide the " 'who, what, when, where, and how' of the alleged fraud." United States ex rel. Gublo v. Novacare, Inc., 62 F. Supp. 2d 347, 354 (D. Mass.1999) (quoting United States ex rel. Thompson v. Columbia / HCA Healthcare Corp., 125 F.3d 899, 903 (5th Cir.1997). There are three purposes behind the Rule 9(b) particularity requirement: "(1) to place the defendants on notice and enable them to prepare meaningful responses; (2) to preclude the use of a groundless fraud claim as a pretext to discovering a wrong or as a 'strike suit'; and (3) to safeguard defendants from frivolous charges which might damage their reputation." New England Data Services, Inc. v. Becher, 829 F.2d 286, 289 (1st Cir.1987); see Franklin, 147 F. Supp. 2d at 46. Cf. Ackerman v. Northwestern Mut. Life Ins. Co., 172 F.3d 467, 469 (7th Cir.1999) ("The purpose (the defensible purpose, anyway) of the heightened pleading requirement in fraud cases is to force the plaintiff to do more than the usual investigation before filing his complaint."). Rule 9(b) is to be read in conjunction with Fed. R. Civ. P. 8(a), which requires a "short and plain statement of the claim" for relief, and, as such, the plaintiff is not required to "plead all of the evidence or

facts supporting it." Franklin, 147 F. Supp. 2d at 46-47. See generally Boston & Maine Corp., 987 F.2d at 855. The Rule 9(b) pleading requirement is relaxed when "the facts underlying the fraud are 'peculiarly within the defendants' control." ' Franklin, 147 F. Supp. 2d at 47 (quoting Boston & Maine Corp., 987 F.2d at 866); see Russell, 193 F.3d at 308; Roby, 184 F.R.D. at 111; Wilkins ex rel. United States v. States of Ohio, 885 F. Supp. 1055, 1061 (S.D. Ohio 1995); see also Thompson, 125 F.3d 899 at 903; United States ex rel. Mikes v. Straus, 853 F. Supp. 115, 119 (S.D.N.Y.1994). In such circumstances, fraud may be pled on information and belief. Thompson, 125 F.3d at 903. Even where allegations are based on information and belief, however, "claims of fraud may not be based upon speculation or conclusory allegations," but fact. Thompson, 125 F.3d at 903 (quoted in United States ex rel. Walsh v. Eastman Kodak Co., 98 F. Supp. 2d 141, 147 (D. Mass.2000)).

*5 As noted by the Fifth Circuit, the False Claims Act grants a right of action to private citizens only if they have independently obtained knowledge of fraud. Russell, 193 F.3d at 309 (citing 31 U.S.C. § 3730(e)(4)). "With this requirement the government seeks to purchase information it might not otherwise acquire." Russell, 193 F.3d at 309. Consequently, as held in Russell, where "documents containing the requisite information [are] possessed by other entities, such as the Healthcare Financing Administration," a qui tam plaintiff is not entitled to the relaxed Rule 9(b) standard. Russell, 193 F.3d at 308; see also Clausen, 198 F.R.D. at 563; United States ex rel. Butler v. Magellan Health Services, Inc., 74 F. Supp. 2d 1201, 1216 (M.D.Fla.1999).

Karvelas alleges repeatedly that the defendants submitted false claims to the United States. [See, e.g., Complaint ¶¶ 78-84, 88, 90.] Karvelas asserts that these claims included "cost reports," which the defendants certified falsely were complete, true, and correct. [Complaint ¶¶ 81-84, 86, 174.] He also refers to false "confirming orders of physicians," and "progress notes." [Complaint ¶ 86.] It is not clear whether he is alleging that those documents were false claims. He argues that the defendants would "wrongfully bill Medicare and/or Medicaid," but does not provide specifics about the nature of the "bills." [Complaint ¶ 86.]

Apart from these general references, however, Karvelas does not state with specificity what the precise claims were. He states that he "witnessed the fraudulent conduct alleged herein," but does not provide specifics regarding the documents submitted to HCFA to make the false claims. [Complaint ¶ 91.]

He refers generally to false "patient evaluations," which were "billed to Medicare and Medicaid," [Complaint ¶ 112], and also refers to "CLIA documents" and "HCFA documents," [FN7] which, he claims, evidence that the Hospital was aware of various "problems" in the blood gas laboratory. But no such documents are identified with particularity in the complaint. [Complaint ¶ 115.]

FN7. As July 1, 2001, the Health Care Financing Administration ("HCFA") is now the Centers for Medicare and Medicaid Services ("CMS").

To be sure, Karvelas outlines several "schemes" in which the defendants participated. But in none of these schemes, labeled "A" through "P," does he allege

violations of the False Claims Act sufficiently to meet his Rule 9(b) obligation.

With respect to these schemes, Karvelas alleges that:

Scheme A. The defendants filed "improper claims in that they presented claims for medical items or service that they knew were not provided as claimed." [Complaint ¶ 129.] Karvelas notes that "accurate reporting of financial information on cost reports and credit balancing" is required by "Medicare and Medicaid," but he does not identify even an example of a specific cost report submitted by the defendants. [Complaint ¶ 128.] Karvelas charges that from 1994 [FN8] to 1997, "the Hospital was certifying 12 respiratory therapists when in reality the hospital had only 7 full time respiratory therapists," [FN9] but provides no particulars regarding this allegation. [Complaint ¶ 140.] In the complaint, Karvelas states that the "documents signed under the penalty of perjury and false statement submitted to the United States Government certified that there were 11.8 Respiratory Therapists," but does not provide any further detail regarding what type of "document" it was, when it was submitted, or by whom it was submitted. [Complaint ¶ 143.] Karvelas elaborates in his affidavit that the hospital submitted a plan to the government that included "representations and promises relating to staffing requirements," but does not provide details regarding its submission. [Karvelas Affidavit ¶ 66.] Karvelas references "documents from DPH and HCFA" that "show dramatically that these staffing levels were bogus from 1994 to 1997," but provides none of these documents. [Affidavit ¶¶ 76, 82.] Karvelas also states that he is in possession of time

sheets that reflect the staffing issues dating from 1996-97 but has not provided this documentation. [Karvelas Affidavit ¶ 69.] Karvelas further states that the "staffing numbers in the Medicare and Medicaid filings were make believe throughout the entire hospital," but provides no further specifics. [Complaint ¶ 144.]

FN8. The defendants contend that, to the extent that the complaint makes claims based on activity that took place in 1994, those claims are outside the FCA's six-year statute of limitations and are subject to dismissal. See 31 U.S.C. § 3731(b)(1). Given my treatment of defendants' motion to dismiss, I need not separately address this argument.

FN9. In his affidavit, Karvelas alleges that the hospital was reporting to the government that it had between 11 to 11.5 respiratory therapists. [Karvelas Affidavit ¶¶ 71-72.]

*6 Scheme B. The hospital performed blood tests "with machinery and equipment that was not tested, or up to code, or certified, and did not meet the standards accepted by the medical community," which were not in compliance with the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") nor had certification from the College of American Pathologists ("CAP"), which Karvelas alleges are required to receive payment under Medicaid and Medicare. [Complaint ¶ 148, ¶ 155, ¶ 164.] Karvelas alleges that the hospital falsely certified the completion of the required tests, but does not provide any further detail regarding this certification. [FN10] [Complaint ¶ 165.] He states in his affidavit that he has copies of these "logs" for the period

of June 1994 through April 1997 but does not provide them to the court. [Karvelas Affidavit ¶ 109.]

FN10. Karvelas also references a Complaint Investigation Report he states was issued by CLIA, after an investigation into the ABG laboratory instigated as a result of Karvelas' complaints to the Massachusetts Department of Public Health. [Karvelas Affidavit ¶¶ 47, 62, 100, 130.] Karvelas quotes extensively from the report, which finds the issues he raised "valid," but he does not attach the report to the affidavit. Moreover, it is not clear how this report substantiates his False Claims Act case; the report would appear to evidence the government's independent knowledge of any potential regulatory violations at the lab. As far as Karvelas' claim for retaliation is concerned, the report was prepared after Karvelas' termination and he provides no evidence that his superiors were under the impression that he had contacted CLIA with concerns. [See Affidavit ¶ 103.]

Scheme C. The hospital "created an unsafe and harmful environment for patients," in contravention of "the statutes and regulations governing Medicaid and Medicare," which "clearly require health care providers to meet quality of care standards." [Complaint ¶¶ 177-78.] Karvelas points to various actions, including those covered in Schemes A and B, as well as the destruction of 250 incident reports. Karvelas alleges that the hospital "submitted claims for reimbursement, and asserted with the claim for reimbursement that it had supplied the requisite standard of care" and,

consequently, "the billing for that care was ... false or fraudulent." [Complaint ¶ 237; see Karvelas Affidavit, Exh. 4, at 16.] He provides no specifics regarding these claims. [FN11]

FN11. Nor does he provide details regarding the private investigator he claims the hospital hired to follow him three weeks before his termination. [Affidavit ¶ 122.]

Scheme D. In contravention of Medicare and Medicaid provisions, which require that services "be certified as being medically necessary," "the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not medically necessary." [Complaint ¶¶ 238-41.] Karvelas alleged personal knowledge of tests that were administered with no medical necessity, [see Complaint ¶¶ 245-62], and alleges that Medicare was billed for these tests, but does not provide any specifics about those claims. Karvelas instead alleges that the "DPH and HCFA investigations serve as documented examples representative of the type of unnecessary medical services that were not documented, but yet were billed." [Complaint ¶ 263.] Without substantiation or elaboration, he adds in his affidavit that, over two and a half years, "66,000 treatments were billed," 20% of which "were billed without documentation." [Karvelas Affidavit, Exh. 3, at 22.]

Scheme E. The hospital engaged in illegal "upcoding," "the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient." [Complaint ¶ 266.] Karvelas alleges specific "codes" to

which the hospital would upcode, [Complaint ¶¶ 285, 287-92], but beyond broad allegations that the hospital would use these codes, Karvelas does not provide specific details such as dates or documentation. Karvelas does state that "death certificates at DPH validated the documentation of upcoding," but it is not clear whether those certificates were claims for payment or merely validated the documentation. [Complaint ¶ 298.] To bolster his upcoding allegations, Karvelas relates the precise numbers of pulmonary disease cases, pneumonia cases, and stroke cases. [Karvelas Affidavit, ¶¶ 218-25.] He does not provide the source of these numbers.

*7 Scheme F. The hospital engaged in various double billing and overcharging practices. [Complaint ¶¶ 301-05.] Once again, the plaintiff states that the hospital knowingly filed improper claims in violation of the False Claims Act, but does not provide particulars--the who, what, when, and where-- about those claims. [Complaint ¶ 303.] In his affidavit, he refers to specific entries of double billing on a "Respiratory Therapy Worksheet." [Karvelas Affidavit ¶ 235.] The Worksheet is not in the record.

Scheme G. The hospital "unbundled tests" and billed for medically unnecessary tests "to gain a higher rate of reimbursement. [Complaint ¶¶ 311-22] Again, he provides no specific instances of these billing practices.
Scheme H. The hospital was using "bogus" numbers in order to gain reimbursement for home oxygen units. [Complaint ¶ 327-28.] The specifics that Karvelas supplies are only that this practice occurred "from 1994 to 1997" and involved "Anthony Dichiara, Melody Rochester and Karen Mahoney." [Complaint ¶ 327-28.]

Karvelas does relate one type of fraud regarding the improper reimbursement of home oxygen. He states that, for three years beginning in September 1994, the hospital "falsified the numbers" to "get Medicare to pay for" home oxygen for a trustee of the hospital. [Complaint ¶ 332.] Karvelas states that, on January 26, 1997, the trustee admitted to Karvelas that "the results were falsified." [Complaint ¶ 332.] In his affidavit, Karvelas identifies the trustee as Barbara Cummings. [Karvelas Affidavit ¶¶ 58, 258, 260-63.] Karvelas does not provide any documentation regarding the false claims specifically involved in this fraudulent billing scheme.

Scheme I. The hospital billed all care as if it were direct care when, in fact, it was providing indirect care. [Complaint ¶¶ 338-39.] Karvelas points to "flow sheets," used from 1995 to 2000 that "did not differentiate between direct care versus indirect care." [Complaint ¶ 342.] He states that in September 1998 Hyland-Miller and Dichiara "came up with a $510 dollar charge for an assessment on the flow sheet." [Complaint ¶ 341.] Karvelas does not state whether these flow sheets were submitted directly to the U.S. government as claims or provide documentation of such claims.

Scheme J. The hospital billed the government for non-covered and unnecessary services "by entering the service under an erroneous code," [Complaint ¶¶ 349, 352-53.] Karvelas alleges that the hospital "submitted charges" and "claims," [Complaint ¶¶ 350-53], but does not provide particulars about the submission of these claims.

Scheme K. The hospital fraudulently listed patients as discharged, rather than transferred, "to receive a higher rate of payment." [Complaint ¶¶ 359, 364.] Karvelas does not provide specifics regarding these claims.

Scheme L. The hospital engaged in a "scheme to defraud" the government by "regularly classifying patients as outpatients" to ensure care would be reimbursable. [Complaint ¶¶ 368-70.] Karvelas states that "time and again after July 1994" that he witnessed patients who were admitted, "but yet claims were submitted for the outpatient visit." [Complaint ¶ 378.] He provides no further specifics.

*8 Scheme M. The hospital billed group therapy sessions as individual sessions to increase the number of bills for reimbursement. [Complaint ¶ 381- 83, 386.] Karvelas also alleges that the hospital billed sleep studies as being attended when they were not. [Complaint ¶ 384.] No further particularities are provided about these billings.

Scheme N. The hospital was involved in kickbacks, self referrals, and conflicts of interest in violation of the FCA. [Complaint ¶¶ 390, 393-412.] He alleges that the defendant hospital steered and channeled patients to a home health company in which it had an interest. [Complaint ¶¶ 390, 393.] He also alleges that Dr. Sen, Dr. Mohammed Akbarian, Dr. Michael Zak, and other hospital staff engaged in "self-referrals" and "conflicts of interest" because they steered patients to home health care facilities in which they had a financial interest. [Complaint ¶¶ 395-98.] Karvelas alleges further that ambulance companies took supplies free of charge from

the hospital, [Complaint ¶ 400-01], that a sales representative for "Medical Home Providers" would provide free nasal masks so that the hospital would refer patients to them, [Complaint ¶ 402], that medical equipment companies were loaning equipment to gain referrals, [Complaint ¶ 407], all of which the hospital would subsequently bill Medicare for. [Complaint ¶ 401, 403, 408-09]. The hospital did not disclose their interest in post-hospital services to patients being discharged. [Complaint ¶ 406]. Karvelas provides no documentation or specifics to substantiate these generalizations.

Scheme O. The hospital changed "the code of the care" to gain reimbursement for all respiratory therapy and pulmonary rehabilitation services, which are not reimbursable under Medicare and Medicaid, according to Karvelas. [Complaint ¶ 415, 417-20; Affidavit Exh. 4 at 40.] Karvelas does not provide information regarding the hospital's use of these codes on specific claims submitted to the U.S. government.

Scheme P. The hospital was engaged in various additional schemes, some already listed above, including "submitting claims for oxygen when the patient didn't use it," [Complaint ¶ 426], charging for oxygen and suction "when all that Medicare allowed was a charge for the initial set up of the Oxygen," [Complaint ¶ 427 (emphasis in original)], and billing for tests and therapy that were not performed, not ordered by a physician, or for which the beneficiary had no legal obligation to pay. [Complaint ¶ 428-31, 445, 447]. Karvelas alleged that the hospital submitted claims for non-reusable and ancillary medical equipment and supplies. [Complaint ¶¶ 433-35.] Karvelas notes specifically that in August 1996, 17 boxes of Albuterol

were donated to the hospital and that Dichiara "used the medications" and subsequently billed Medicare for them. [Complaint ¶ 437.] He states that "a claim was made," but does not state any particulars regarding that claim. Karvelas relates that the hospital would bill for administrative costs such as "taking physicians and their wives out for dinner," "alcohol and entertainment," and sporting events. [Complaint ¶ 438.] According to Karvelas, patients admitted to the hospital continued to be charged the full rate by "the Home Care Companies," [Complaint ¶ 440], a hospital employee would "score sleep studies and bill Medicare $70 per patient" and was "double dipping" with the approval of the hospital, [Complaint ¶ 441], and nurses made visits to patients' residences while they were not home and the nurses billed Medicare for the visits, [Complaint ¶ 442]. Karvelas was allegedly not reimbursed for travel expenses he billed to the hospital, but the hospital "was reimbursed by the Government." [Complaint ¶ 443.] Finally, Karvelas alleges that ambulance service was billed when it was not medically necessary, [Complaint ¶ 446]. He provides no specifics regarding any of these billing activities.

*9 The present complaint demonstrates the proposition that a "complaint can be long-winded, even prolix, without pleading with particularity. Indeed, such a garrulous style is not an uncommon mask for an absence of detail." Williams v. WMX Technologies, Inc.., 112 F.3d 175, 178 (5th Cir.1997). Karvelas has provided a lengthy False Claims Act complaint, without particulars necessary to meet Rule 9(b) obligations. Nor does he provide reference to actual documentation, which it bears emphasizing is not exclusively in the hands of the defendants, but, having been filed with the

government, is in the government's hands as well. Under these circumstances, I will grant defendants' motion to dismiss on Counts I, II, and III for failure to plead fraud adequately.

2. Count IV: False Claims Act Retaliation

Karvelas's fourth cause of action is for "Retaliation" or "Wrongful Termination" pursuant to 31 U.S.C. § 3730(h). As he did in Karvelas I, Karvelas in this action again contends that he was discharged in retaliation for his investigation of "defendants' violations of its government contracts under Medicaid and Medicare and its False Claim Act violations." [Complaint ¶ 461.]

a. Res judicata

I dismissed the similar False Claims Act claim in Karvelas I for failure to state a claim upon which relief could be granted. I noted in my Karvelas I Memorandum and Order dated December 19, 2000 the three elements that courts have found to constitute a False Claims Act retaliation claim: " '(1) the employee must be engaged in conduct protected by the statute, (2) the employer must know the employee was engaging in such protected conduct, and (3) the employer must have discriminated against the employee because of this protected conduct.' Gublo v. Novacare, 62 F. Supp. 2d 347, 356 (D. Mass.1999)." Slip op. at 2. I found there that Karvelas failed to allege facts sufficient to constitute the first two requirements and, as a consequence had failed also adequately to allege the third requirement, which is dependant upon the first two.

Defendants urge that Court IV should be dismissed on res judicata grounds. Under federal law, "a final judgment on the merits of an action precludes the parties or their privies from relitigating issues that were or could have been raised in that action." In re Colonial Mortgage Bankers Corp., 324 F.3d 12, 16 (1st Cir.2003) (quoting Allen v. McCurry, 449 U.S. 90, 94, 101 S.Ct. 411, 66 L.Ed.2d 308 (1980)).

There is some authority in the First Circuit for the proposition that dismissal under rule 12(b)(6) operates as a dismissal on the merits with res judicata effect. See, e.g., Isaac v. Schwartz, 706 F.2d 15, 17 (1st Cir.1983) (citing Restatement (Second) of Judgments § 19 (comment d)); Andrews-Clarke v. Lucent Technologies, Inc., 257 F. Supp. 2d 93, 99 (D. Mass.2001) (citing 2 James Wm. Moore, Moore's Federal Practice, s 12.34[6] [a] (3d ed.1997)). However, I am reluctant to ground dismissal on this basis because my order of dismissal in Karvelas I noted that plaintiff's False Claims Act litigation was in its early states. In any event, I find that the plaintiff again fails to state a claim upon which relief can be granted in Count IV.

b. Substance of retaliation claim

*10 [2] Turning to the substance of the allegations in the retaliation claim, I reiterate that there are three elements a plaintiff must prove to state a § 3730(h) claim: "(1) the employee must have been engaging in conduct protected under the Act; (2) the employer must have known that the employee was engaging in such conduct; and (3) the employer must have discriminated against the employee because of her protected conduct." United States ex rel. Hopper v. Anton, 91

F.3d 1261, 1269 (9th Cir.1996); see Gublo v. Novacare, Inc.., 62 F. Supp. 2d 347, 356 (D. Mass.1999); see also S.Rep. No. 345, 99th Cong., 2d Sess. 34-35 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5299-300. On the face of the complaint, the plaintiff has not alleged facts sufficient to sustain a claim of retaliation under the False Claims Act.

Section 3730(h) only protects employees "who have acted 'in furtherance of an action' under the FCA," regardless of their awareness of the precise statute. Hopper, 91 F.3d at 1269. The plaintiff must be "investigating matters which are calculated, or reasonably could lead, to a viable FCA action." Hopper, 91 F.3d at 1269. The plaintiff must demonstrate that his "investigation inquiries and/or testimony were directed at exposing a fraud upon the government." Gublo, 62 F. Supp. 2d at 356; see Hopper, 91 F.3d at 1269. Protected activity includes "investigating fraud" with a goal of "trying to recover money for the government," not simply "correcting regulatory problems." Hopper, 91 F.3d at 1269. It is sufficient for the purposes of a False Claims Act retaliation claim that a plaintiff be investigating matters that reasonably could lead to a viable FCA case, even if a private qui tam suit is never initiated. United States ex rel. Yesudian v. Howard Univ., 153 F.3d 731, 740 (D.C.Cir.1998), aff'g in part and rev'g in part, 946 F.Supp. 31, 33 (D.D.C.1996).

Second, the employer must be aware that the employee is investigating fraud. Hopper, 91 F.3d at 1269. The defendant must know that the plaintiff is engaged in an activity "that reasonably could lead to a False Claims case." Yesudian, 153 F.3d at 742. Such activity "includes the investigation of 'false or fraudulent claims' made to federal grantees." Yesudian, 153 F.3d at 742. [FN12]

Like the plaintiff, however, "the defendant need not know, or be advised, that such claims would violate the False Claims Act itself." Yesudian, 153 F.3d at 742. A plaintiff must show that his employer was aware of the protected activity, and "[m]erely grumbling to the employer about job dissatisfaction or regulatory violations does not satisfy the requirement--just as it does not constitute protected activity in the first place." Yesudian, 153 F.3d at 743.

FN12. Cf. Gublo v. Novacare, Inc., 62 F. Supp. 2d 347, 357 (D. Mass.1999) (stating that a defendant must have implicit or explicit notice that a "plaintiff was either taking action in furtherance of a private qui tam action or assisting in an FCA action brought by the government") (quoting United States ex rel. Yesudian v. Howard Univ., 946 F.Supp. 31, 33 (D.D.C.1996), aff'd in part and rev'd in part, 153 F.3d 731, 740 (D.C.Cir.1998))

Therefore, where the employee has not given any indication to the employer that he was conducting an investigation of the hospital for defrauding the federal government, a defendant who engages in retaliation for a plaintiff's investigative activities does not violate § 3730(h) of the FCA. Hopper, 91 F.3d at 1270.

*11 For example, in Luckey v. Baxter Healthcare Corp., the plaintiff, Joan Luckey, claimed she had been dismissed for exposing the false claims of her employer, Baxter Healthcare Corporation. Luckey, 183 F.3d 730 (7th Cir.1999). Luckey argued that Baxter was aware of "an investigation for" suit or at least the possibility that she assisted in a suit to be filed because Baxter "knew

her position that every unit of incoming blood plasma should be subject to a total protein test." Luckey, 183 F.3d at 733. The court rejected Lucky's contention, holding that Baxter could not be said to have "knowledge of litigation": "Intra-corporate debates about optimal testing protocols cannot be equated to knowledge of litigation--not unless taking one side of a medical or scientific dispute is 'fraud,' a position we have already rejected. An employer is entitled to treat a suggestion for improvement as what it purports to be rather than a precursor to litigation." Luckey, 183 F.3d at 733.

A similar situation is presented here. In the complaint, Karvelas states:

> Throughout John Karvelas' employment at Melrose-Wakefield, he complained to management about deficiencies in the care and about the activities hereinbefore related within his department and throughout the Hospital.

[Complaint ¶ 459.] In his opposition to defendant's motion to dismiss, the plaintiff argues that the language "hereinbefore related" is all the "various fraudulent schemes set forth in the Qui Tam complaint," language which then presumably encompasses all the previous 458 paragraphs. It is not sufficient to plead in this paragraph that "he complained to management about" each activity pled in the previous 458 paragraphs. Instead, I will look to those paragraphs in the complaint that specifically speak to plaintiff's False Claims Act retaliation claim.

The complaint includes a number of allegations regarding his communications with hospital staff, none of which constitute notice that the plaintiff was investigating fraud and, thus, none of which concern conduct protected under the False Claims Act:

> (1) "The Relator John Karvelas notified the Hospital's CEO and President, Richard S. Quinlan in 1994 in which he, the Relator, delineated the substandard patient-care practices that he had observed, and he suggested alternative procedures." [sic] [Complaint ¶ 101.] [FN13]

FN13. In response, according to Karvelas, Quinlan "took no remedial actions" and, instead, "stated at many management meetings in which the Relator's statements were read, that whoever wrote the letters should be terminated." [Complaint ¶ 102.]

> (2) "In 1995, the Relator went to the Vice-President for Nursing Services, Sharon O'Connor, and reported how dangerous it was at the Hospital with the under-staffing and with no backup system in place." [Complaint ¶ 103.]
>
> (3) According to Karvelas, Hyland-Miller was "specifically aware" of the fact that, because of "increased workload and reduced workforce," "many of the therapists were unable to perform all of their duties, including the quality controls

on the ABG test machines." [Complaint ¶¶ 162-63.] These problems were brought to the hospital's attention by Karvelas. [Complaint ¶ 163.]

*12 (4) "The Relator intervened to prevent a patient from going into cardiac arrest and when he reported the neglect, he was told by Karen Miller that he had left a syringe on top of a sharps box with a rubber cap on it." [Complaint ¶ 212.]

(5) "John Karvelas discovered that Physical Therapy was documenting in patients' charts that chest physical therapy was not indicated. The Relator and other Respiratory Therapists got called to the floors when patients were drowning in their own secretions." [Complaint ¶ 214.]

(6) In October 1996, Karvelas gave names to Quality Assurance relating that "practitioners" were filling out incident reports "related to neglect, abuse, medical errors and inferior care" and "verified that Brenda Hyland-Miller had been destroying the incident reports." [Complaint ¶ 220.]

(7) "The Relator on repeated occasions brought the neglect to the attention of Hospital officials and to his superiors, reporting in 1994, 1995, 1996 and 1997 how dangerous it was with the under-

> staffing and with no backup system in place. No remedial actions were taken." [Complaint ¶ 231.] "In fact, the Relator provided Richard Kenny with documentary evidence of the problems, including the fact that his supervisors had destroyed incident reports regarding medical errors and patient neglect. Mr. Kenny took no actions in response to the reports the Relator had given him." [Complaint ¶ 232.]

Notice of False Claims Act activity cannot be inferred from these statements to hospital staff. These statements could give the hospital no indication that Karvelas was conducting an investigation of the hospital for defrauding the federal government within the meaning of the False Claims Act. [FN14] Whether or not he was engaged in such an investigation, at most, Karvelas appeared to be raising with his employer problems of job dissatisfaction and regulatory violations.

FN14. Karvelas details only the hospital's awareness of his reporting to state authorities. Karvelas alleges in his affidavit that he reported fraud to state authorities in September 1996 and that the hospital "had to have known" about the reporting. [Affidavit ¶¶ 130, 162.] Furthermore, as mentioned above, in his affidavit Karvelas does allege that, after he filed a complaint with the Massachusetts Department of Health in January 1997 before his termination, the hospital hired a private detective to "keep tabs" on him. [Karvelas Affidavit, Exh. 2, ¶ 64.]

Karvelas does state that he reported to his employer problems with improper Medicaid and Medicare billing, but the fact that he reported these problems does not mean that he gave notice to his employer that he was conducting an investigation of the hospital's billing practices as a precursor to a False Claims Act proceeding. [See Complaint ¶¶ 112, 175.]

Finally, in the portion of the complaint that details Karvelas's termination, Karvelas alleges that he was told he was being terminated for reporting, to Dr. Lilly and Dr. Sen, "the failure of the hospital to meet patient care standards" and, for reporting to a state senator, "allegedly unsafe conditions." [Complaint ¶ 119.] Investigations of allegedly unsafe conditions or unsatisfactory patient care standards are, while certainly laudable, are not themselves protected conduct under the False Claims Act. [FN15]

FN15. I, of course, express no view whether termination for such activities, if proved, would establish a state law claim.

Given the plaintiff's continued inability to state a claim for False Claims Act retaliation, I will grant defendants' motion to dismiss on Count IV.

3. Count V: RICO Claim

*13 The defendants seek to dismiss plaintiff's RICO claim arguing that the plaintiff lacks standing to bring a RICO claim because he has not suffered any injury and that he has failed to plead with particularity under Fed. R. Civ. P. 9(b).

In the complaint, Karvelas charges that:

> In an effort to defraud the United States of America, the defendants by telephone and through the United States Mail, and in contact with vendors, contractors, subcontractors and agents, servants and or employees of the said defendants and agents, servants, and or employees of the United States Government, made numerous false and fraudulent statements to representatives of the U.S. Government concerning costs, claims, submissions, and pricing data.

[Complaint ¶ 466.]

[3] Putting aside whether Karvelas has satisfied the particularity requirements of Rule 9(b) as applied to RICO pleadings, see Ahmed v. Rosenblatt, 118 F.3d 886, 889 (1st Cir.1997), or otherwise met RICO pleading requirements, I find that the plaintiff lacks standing to bring a claim under 18 U.S.C. § 1962 because the nexus between the violations asserted by Karvelas and any injuries to him is "insufficiently close to say that one proximately caused the other." See Camelio v. American Federation, 137 F.3d 666, 670 (1st Cir.1998); see also Miranda v. Ponce Federal Bank, 948 F.2d 41, 47 (1st Cir.1991); Pujol v. Shearson / American Express, Inc., 829 F.2d 1021, 1025 (1st Cir.1987).

Karvelas alleges in the Complaint that the defendants "by telephone and through the United States Mail ... made numerous false and fraudulent statements to representatives of the U.S. Government concerning

costs, claims, submissions, and pricing data." [Complaint ¶ 466.] He does not allege any injury he himself suffered as a result of these predicate acts, however. [See Complaint, Count V, ¶¶ 464-68.]

The First Circuit found in Pujol v. Shearson / American Express, Inc. that because the acts that injured the plaintiff were not caused by the "predicate acts" alleged in the complaint, Pujol did not have RICO standing. Pujol, 829 F.2d at 1205. Like Pujol, Karvelas was not a defrauded party and was not a target of any of the acts pleaded as "predicate acts" in the RICO claim. See Pujol, 829 F.2d at 1205. At most, Karvelas alleges that he was fired because of the actions he took to report and to stop the illegal schemes. [See Complaint at ¶¶ 112, 114, 119, 461, 462.] His termination is far too attenuated from the underlying fraud; it did not involve a RICO predicate and moreover I have twice found it inadequately pled as a federal False Claim matter. Consequently, I find Karvelas lacks standing to bring a claim under RICO and I will grant defendants' motion to dismiss on Count V.

III. CONCLUSION

For the reasons set forth more fully above, I hereby GRANT defendants' motion to dismiss (No. 21) and I do so with prejudice. [FN16]

FN16. I make this dismissal with prejudice in recognition that the plaintiff has been engaged in False Claims Act litigation in this court since May 2000. It should be clear to him now that developing the information necessary to meet pleading obligations is a necessary task to

overcome sufficiency challenges. It is apparent the plaintiff is content to rest with conclusory pleadings in conducting his federal litigation. I was reluctant, as I indicated in Section II.B.2.a. of this memorandum, to accord res judicata effect to my dismissal of his False Claims Act retaliation claims (let alone, as defendants argued here more broadly, any other claims which could have been made in Karvelas I--including the claims made in this action) when in 2000 the plaintiff was in the beginning stages of his federal litigation. With the instant dismissal of the defendants' partially repetitive litigation in this case, however, that reluctance has disappeared. Plaintiff has had ample opportunity to sharpen his pleadings (and indeed to conduct parallel fact gathering by alternative means, for example, under the Freedom of Information Act) but his allegations continue to be insufficient. Under the circumstances, it is now appropriate to enter final judgment in this litigation with recognition and anticipation that it is on the merits and thereby precludes the plaintiff and his privies from relitigating issues that were or could have been raised in this action.

However, I note that this judgment is not a intended to be with prejudice to any claim that the federal government, which chose not to intervene in plaintiff's qui tam proceeding, could have raised in this action. The government remains free to exercise its discretion and judgment regarding its own litigation posture with respect to matters related to or suggested by claims the plaintiff has unsuccessfully

presented to this court.

D. Mass.,2003.
U.S. ex rel. Karvelas v. Melrose-Wakefield Hosp.
2003 WL 21228801 (D. Mass.), RICO Bus.Disp.Guide 10,483
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No. 03-1901

United States Court of Appeals For the First Circuit

UNITED STATES ex rel. JOHN C. KARVELAS
Plaintiff - Appellant

v.

MELROSE - WAKEFIELD HOSPITAL; MELROSE - WAKEFIELD HEALTHCARE CORPORATION; HALLMARK HEALTH SYSTEM, INC.
Defendants – Appellees

Entered: March 25, 2004

BeforeBoudin, Chief Judge, Coffin, Senior Circuit Judge, Selya, Lynch, Circuit Judges, Lipez, Howard and Barbadoro, Circuit Judges.

ORDER OF COURT

The panel of judges that rendered the decision in this case having voted to deny the petition far rehearing and the suggestion for rehearing en banc having been carefully considered by the judges of the Court in regular active service and a majority of said judges not having voted to order that the appeals be heard or reheard by the Court en banc,

It is ordered that the petition for rehearing and the suggestion for rehearing en banc, be denied.

By the Court:
RICHARD CUSHING DONOVAN, Clerk

[CC: John F. Murphy, Oliver B. Dickins, Esq., Alex H. MacDonald, Esq., Sara M. Bloom, Esq., Michael K. Fee, Emily C. Shanahan, Esq.]

COMPLAINT

This cause, and this original Complaint, is filed "IN CAMERA" and is sealed pursuant to 31 U.S.C. § 3730(b)(2).

This is a *qui tam* proceeding brought by Relator John C. Karvelas for and on behalf of the United States of America, and is filed IN CAMERA and is sealed pursuant to 31 U.S.C. § 3730(b)(2). The Relator requests that this matter remain IN CAMERA and sealed subject to an investigation of the allegations set out herein by the Office of the Attorney General of the United States, and by the office of the United States Attorney for this District. A copy of this Complaint is now served on John Ashcroft as Attorney General of the United States at the Department of Justice, 10th & Constitution Avenues, N.W., Washington, D.C. 20530, and on Donald K. Stern, Esq., United States Attorney for the Massachusetts District, One Court House Way, Boston, MA 02210.

I. NATURE OF ACTION

This is an action to recover damages and civil penalties from Melrose-Wakefield Hospital, Melrose-Wakefield Healthcare Corp., and Hallmark Health Systems, Inc for making false statements to the United States Department of Health and Human Services and for submitting false claims regarding services and medical equipment provided at Melrose-Wakefield Hospital beginning in 1994 to the present. The defendant Hospital, and its parent corporations, as well as the other health care facilities - Whidden, Lawrence Memorial and Malden Hospitals - owned and operated

by Hallmark Health Systems, Inc., engaged in a massive scheme to submit false and fraudulent claims for payment to the United States Government under Medicare and Medicaid.

In these claims for payment the Hospital and its parent corporations certified that medical services and equipment were provided in compliance with the standards established by the Health Care Financing Administration (HCFA) which were required for reimbursement, when in fact services and medical equipment were not provided, or were provided in such an improper manner, or were falsely certified has having been provided in compliance with HCFA. The claims violated the defendants' certifications that the filed Medicare and Medicaid cost reports and submissions were a "true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions," as required by federal law and regulation. 42 C.F.R. § 413.24(f)(4)(iv).The Government was defrauded when it paid the claims.

II. PARTIES

1. The United States brings this action on behalf of its agencies, the Department of Health and Human Services ("HHS") and its component, the Health Care financing Administration ("HCFA"), and on behalf of the Medicare and Medicaid programs.

2. The Relator Plaintiff John C. Karvelas is an adult resident of Wakefield, Massachusetts. At all times relevant to this action he worked as a

Respiratory Therapist at the defendant Melrose-Wakefield Hospital or was a former employee of the Hospital. The Relator began his employment as a licensed Respiratory Therapist with the defendant Hospital in 1982. He brings this action for violations 31 U.S.C. §§ 3729 et seq.,of the Federal False Claims Act on behalf of himself and the United States pursuant to 31 U.S.C. § 3730(b)(1). The Plaintiff Relator has direct and personal knowledge of false records and statements prepared by the defendant Melrose-Wakefield Hospital and its parent corporations and submitted as claims to the United States and the Commonwealth of Massachusetts as alleged herein. Plaintiff voluntarily provided the United States of America with substantial material evidence and information supporting allegations set forth herein, pursuant to 31 U.S.C. § 3729, et seq. In June, 1997 the Relator divulged the fraud to MCAD. In July, 1997, the Relator John Karvelas first met with Marshall Stone of the FBI with his concerns. In July, 1997, the Relator filed a complaint with JCAHO regarding inferior and substandard care and the destruction of incident reports and legal documents at the defendant Melrose-Wakefield Hospital. In the summer of 1999, the Relator Jack Karvelas met with the FBI relating to the wrongful deaths at the hospital as well as false claims matters. By virtue of the foregoing facts, the Relator has established himself as the original source of the information possessed by the United States regarding these claims.

3. The defendant Melrose-Wakefield Hospital (hereinafter referred to as the Hospital) is a Massachusetts corporation located in Melrose, Massachusetts. The Hospital is a subsidiary of the defendant Melrose-Wakefield Healthcare Corporation.

4. The defendant Melrose-Wakefield Healthcare Corporation (hereinafter referred to as Healthcare) is a Massachusetts corporation and a subsidiary of the defendant Hallmark Health Services, Inc.

5. The defendant Hallmark Health Services, Inc. (hereinafter referred to as Hallmark) is a Massachusetts corporation with its principal place of business in Malden, Massachusetts. The defendant Hallmark Health Services, Inc. is the parent of Whidden, Lawrence Memorial and Malden Hospitals as well as Melrose-Wakefield Hospital.

6. The acts of the agents, servants and employees of Melrose-Wakefield Hospital alleged herein are effectively the acts of the Hospital, as well as those of the Hospital's parent corporation, Melrose-Wakefield Healthcare Corporation, as well as the acts of Hallmark Health Services, Inc., which is the parent and principal of Melrose-Wakefield Healthcare Corporation.

III. JURISDICTION AND VENUE

7. This is a civil action arising under the laws of the United States to redress violations of the Federal False Claims Act under the qui tam provisions of 31 U.S.C. § 3730(b). This Court has subject matter jurisdiction pursuant to 28 U.S.C. §1331, §1345 and 31 U.S.C. § 3732. Under the Second Count the Court has jurisdiction pursuant to 18 U.S.C. §§1961(a) and 1961(5) and 18 U.S.C. §1962.

8. Venue is proper in this District pursuant to 31 U.S.C. § 3730(b), § 3732(a) and 28 U.S.C. § 1331 because Defendants can be found in, and to have transacted business in, the District of Massachusetts. In addition, all of the specific wrongful acts described hereinafter occurred in the District of Massachusetts.

IV. FALSE CLAIMS ACT

9. The False Claims Act, 31 U.S.C. §3729 provides, inter alia:

(a) Liability for certain acts. Any person who--

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or dbt, public property from an officer or employee of the Government, or a member of the Aermed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person...

10. Said Act goes on to provide, in §3730, in pertinent part:

(a) Responsibilities of the Attorney General.--The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.--(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20

days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall--

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to Qui Tam actions. -- (1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action...

(d) Award to Qui Tam plaintiff. -- (1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall

also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

V. THE MEDICARE PROGRAM

11. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare" or the "Medicare Program") to pay for the costs of certain health services and health care. Entitlement to Medicare is based on age, disability or affliction with end-state renal disease. See 42 U.S.C §§ 426, 426 A. Part A of the Medicare program authorizes payment for instututional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C §§ 1395c-1395I-4. Most hospitals, including all of defendants' owned and managed hospitals, derive a substantial portion of their revenue from the Medicare program.

12. Prior to October, 1983, Medicare reimbursements were based on the "reasonable cost" of inpatient services provided to Medicare beneficiaries. Under the reasonable cost payment system, providers were reimbursed for the actual costs they incurred, provided that the costs fell within certain cost limits. 42 U.S.C § 1395f(b). Thus as hospital costs increased, so too did Medicare reimbursements to those hospitals.

13. Concerned about escalating Medicare expenditures, Congress in 1983 revised the scheme for reimbursing inpatient hospital costs by establishing the prospective payment system ("PPS"). Under PPS, most hospitals, including defendants owned and managed hospitals, are paid on the basis of prospectively determined fixed rates, which vary according to the type and category of hospital treatment received. 42 U.S.C § 1395ww(d). The specific rate to be paid depends upon which diagnosis related group ("DRG") best characterizes the patient's condition and treatment. Id.

14. After 1983, hospitals could request that Medicare exempt them from the PPS system and permit them to remain under the reasonable cost reimbursement system. In addition, by statute, some specialty hospitals, including psychiatric hospitals, are exempt from PPS. 42 C.F.R §§ 412.20, 27.

15. Because PPS reimbursement does not apply to outpatient hospital costs or the costs of certain hospital subproviders, including home health agencies ("HHAs") – which are reimbursed on the basis of the provider's represented costs – providers have an incentive to assign costs to outpatient areas and to cost-based subproviders such as HHAs, whether or not they properly belong there, in order to obtain more Medicare reimbursement than they would have had the costs been properly assigned to the inpatient areas covered by the fixed rate PPS.

16. HHS is responsible for the administration and supervision of the Medicare program. HCFA is a division of HHS and is directly responsible for the administration of the Medicare program. To assist in the administration of Medicare Part A, HCFA contracts with "fiscal intermediaries." 42 U.S.C § 1395h. Fiscal intermediaries typically are insurance companies that provide a variety of services, including processing and paying claims and auditing cost reports.

17. During the year, providers, such as hospitals, submit claims to their assigned fiscal intermediaries for reimbursement, based upon the number of hospital stays for Medicare beneficiaries. 42 C.F.R. §§ 413.1, 413.60, 413.64. Providers receive payments on these claims, known as "interim payments." Within a specified time after the end of the year, the hospital must submit its cost report to its fiscal intermediary so that the fiscal intermediary can make year-end adjustments to the amount paid to the hospital, as needed. 42 C.F.R. §§ 413.20(b).

18. Cost reports contain specific financial data relating to the provider, most importantly the reimbursable costs it expended to care for Medicare patients. Hence, the cost report forms the basis for a determination by Medicare whether the provider is entitled to more reimbursement than already paid it in the interim payments, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

VI. PREPARATION OF THE MEDICARE COST REPORT

19. HCFA requires hospitals, as a prerequisite to payment by Medicare, to submit annually a form HCFA-2552, titled the "Hospital and Hospital health Care Complex Cost Report." ("Hospital Cost Report")

20. HCFA periodically revises the form HCFA-2552, and a given version is indicated by inclusion of the date and year in the form title of the revised version. For example, the HCFA-2552 form is for hospital cost reporting periods ending on or after what is usually the fiscal year of the hospital.

21. To complete a Hospital Cost Report, the provider must review and submit a substantial amount of information to the fiscal intermediary.

22. Before completeing the Hospital Cost Report, a provider reviews its own books and records. The provider then breaks down its costs into a trial balance of expenses.

23. The Hospital Cost Report contains four major parts or Worksheets.

24. First, the provider completes a worksheet of the hospital cost report, titled the "Reclassification and Adjustment of Trial Balance of Expenses." Worksheet A starts with the provider's trial balance of expenses. The provider's trial balance

of expenses includes all of the provider's costs whether they are allowable or unallowable for Medicare reimbursement purposes.

25. The provider then reclassifies the trial balance of expenses in accordance with the Medicare statute, regulations and HCFA program instructions.

26. Next, a provider makes certain adjustments in Worksheet A also in accordance with the Medicare statute, regulations and HCFA program instructions in order to separate out its costs which are unallowable for Medicare reimbursement purposes.

27. Second, the provider fills out Worksheet B of the Hospital Cost Report, titled "Cost Allocation." A provider has to allocate (assign) all of its allowable overhead costs, such as housekeeping or depreciation, to all its revenue producing cost centers, such as operating rooms or laboratories.

28. Third, the provider prepares Worksheet C of the Hospital cost Report titled "Computation of Ratio of Costs to Charges." Charges are the amounts billed throughout the year to Medicare and non-Medicare patients for services rendered. Since Medicare reimburses hospitals based (in part) on their costs, the hospitals need to compute this ratio to determine whether Medicare charges have covered Medicare costs. On Worksheet C, a provider develops cost-to-charge ratios by specific departments, or "cost centers," within the hospital, e.g., the emergency room, the radiology department, et cetera. The

ratio is derived by dividing the total costs, direct and indirect, allocable to the cost center by the amount of the charges generated by the cost center during the same time period. This cost-to-charge ratio allows the provider to apportion costs to Medicare patients on the Worksheet D series.

29. Fourth, the provider completes the Worksheet D series of the Hospital Cost Report. In order to determine Medicare's share of the provider's total costs, the Worksheet D series apportions these costs to the Medicare program on the basis of the cost-to-charge ratios and per diem amounts.

30. For items and services subject to reasonable cost reimbursement, the Worksheet D series completes the process of determining Medicare reimbursement of such items and services. For items and services payable under PPS, the Worksheet D series determines Medicare's liability for the provider's inpatient costs.

31. The inpatient liability for acute care hospitals is determined by the interim claims submitted by the provider for particular patient discharges during the course of the fiscal year. These claims are then summarized on the Provider Statistical and Reimbursement Report and entered on the settlement worksheets as the program liability for inpatient acute care hospital services.

32. After determining Medicare's share of the provider's cost and/or determining Medicare's

liability under PPS, the provider brings these costs forward to the Worksheet E series of the Hospital Cost Report. These costs are then totaled to determine Medicare's true liability for services rendered to Medicare beneficiaries during the course of the fiscal year. The Worksheet E series then subtracts the amount of interim payments made to the provider based upon the payments made on claim-by-claim basis. The difference is the amount due the Medicare program or the amount due the provider.

33. Every Hospital Cost Report contains a "Certification," which must be signed by the chief administrator of the provider or a responsible designee of the administrator.

34. Providers who file their Hospital Cost Reports electronically are required to submit a paper certification to the fiscal intermediary, which must be signed and dated. 42 C.F.R. § 413.24(f)(4).

35. For cost reporting periods prior to approximately 1992, the certification provision in the Hospital Cost Report required the responsible provider official to certify, in pertinent part, that

> To the best of my knowledge and belief, it [the Hospital Cost Report] is a true, correct and complete statement prepared from the books and records of the

provider in accordance with applicable instructions. HCFA Form 2552.

36. Thus to comply with the three-pronged certification requirement, a provider hospital must include the required data and information in accordance with applicable instructions.

37. The provider must certify that the filed cost report is (1) truthful, i.e, that the cost information contained in the report is true and accurate, (2) correct, i.e., that the provider is entitled to reimbursement for the reported costs in acordance with applicable instructions, and (3) complete, i.e., that the Hospital Cost Report is based upon all of the provider's cost information pertaining to the dtermination of reasonable cost.

38. As to the cost reports for years from 1992 on, the certification provision of the Hospital Cost Report was revised by Medicare to include in addition to the above, the following sentence:

> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

39. The provider signs the certification under the pain and penalty of perjury.

40. The Medicare program depends heavily upon the truthfulness of providers in completing their cost reports. It is common knowledge in the healthcare industry that the government lacks adequate resources to conduct a full-scope audit of each of the over 35,000 providers nation wide, including hospitals, which file cost reports with Medicare each year.

41. Defendants took advantage of the Medicare program's limited resource by submitting false claims and false statements in their hospital cost reports with the expectation that they would not be discovered upon audit.

42. HCFA conditions both interim and year-end payments on the truthfulness of the statements contained in the cost report and, as explained herein, relies on this information in determining the provider's payment. 42 C.F.R. § 413.20(e).

43. HCFA considers any cost report containing a false statement that affects reimbursement to be invalid.

VII. APPLICABLE INSTRUCTIONS

44. Medicare requires providers to maintain complete and accurate cost information and to prepare their cost reports based on that information. Because Medicare fiscal intermediaries need to audit a provider's cost information, a provider must make available its complete cost records. The pertinent Medicare regulations provide that:

> (1) The provider must furnish such information to the intermediary as may be necessary to (i) Assure proper payment by the program...(ii) Receive program payment; and (iii) Satisfy program overpayment determinations. 42 C.F.R. § 413.20(d).
>
> (a) Principle. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.
>
> * * *
>
> (c) Adequacy of cost information. Adequate cost information must be obtained from the provider's records to support payments made for service furnished to beneficiaries.

45. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended 42 C.F.R. § 413.413.24.

46. HCFA's Provider Reimbursement Manual ("PRM") contains additional instructions to providers for the perparation of their cost reports. It states that

> Providers receiving payment on the basis of reimbursable cost must provide

> adequate cost data based on financial and statistical records which can be verified by qualified auditors...

PRM § 2300.

47. In addition,

> A participant provider of services must make available to its intermediary its fiscal and other records for the purpose of determining its ongoing record keeping capability. The intermediary's examination of such records and documents are necessary to ascertain information pertinent to the determination of the proper amount of program payments due the provider.

PRM § 2300.

48. Thus, under the applicable regulations and instructions, a Medicare cost report must be based upon all of the provider hospital's cost records, which must then be made available to Medicare for examination. 42 C.F.R. §§ 413.20(d), 413.24; PRM (Part 1) §§ 2300, 2304, 2304.1.

49. A provider hospital may not conceal or withhold pertinent financial data it knows, or should know, potentially affects the amount of Medicare reimbursement properly owing to the hospital.

50. The applicable instructions contain procedures for a provider to include in a Hospital Cost Report non-allowable items that the provider believes should be reimbursable and for which the provider whishes to dispute the determination of non-allowability. This procedure allows the provider to file a cost report under protest as long as the costs protested are disclosed to the Medicare fiscal intermediary. The instructions provide

> You are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. Include the non-allowable item in the cost report in order to establish an appeal issue, and the disputed item must pertain to the cost reporting period for which the cost report is filed. Retroactive application of any decision from adjudicated issues are governed by § 2931.1 of HCFA Pub. 15-I. PRM (Part II) § 115.
>
> When you file a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed. PRM (Part II) § 115.1
>
> The effect of each nonallowable cost report item is estimated by applying reasonable methodology which closely

approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, you must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the intermediary to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s). PRM (Part II) § 115.2.

If you deliberately include cost, without disclosing the fact, in the provider cost report that is nonreimbursable under the regulations, you are subject to those provisions concerning suspect fraud or abuse. Where you fail to comply with the requirements for filing cost reports under protest as set forth above, such cases are referred to the HCFA Regional Office. PRM (Part II) § 115.3

51. Defendants are and were familiar with the Medicare law, regulations, instructions, and the PRM governing the preparation and submission of Medicare cost reports.

52. In addition, if a hospital discovers errors and omissions in its claims submitted for reimbursement to Medicare (including its cost reports), it is required to disclose those matters to its fiscal intermediary. 42. U.S.C. § 1320A-7b(a)(3) creates a duty to disclose known errors in cost reports:

> Whoever... having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment...conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized ... shall in the case of such a ... concealment or failure...be guilty of a felony.

VIII. MEDICAID.

53. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The federal involvement in Medicaid is largely limited to providing matching funding and ensuring that the states comply with minimum standards in the administration of the program.

54. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding, which is called federal financial participation ("FFP") 42 U.S.C. § 1396, et seq.

55. Each state's Medicaid program must provide hospital services. 42 U.S.C. § 1396a(10)(A), 42 U.S.C. § 1396d(a)(1)-(2).

56. Provider hospitals participating in the Medicaid program file annual cost reports with the single state agency administering the particular state's Medicaid program, or its intermediary, in a protocol similar to the one governing the submission of Medicare cost reports.

57. In some states provider hospitals participating in the Medicaid program file a copy of their Medicare cost report with the Medicaid program which is then used by Medicaid or its intermediaries to calculate Medicaid reimbursement. In other states provider hospitals file a separate Medicaid cost report.

58. Providers incorporate in these separate Medicaid cost reports the same type of financial data contained in their Medicare cost reports, and include data concerning the number of Medicaid patient days at a given facility.

59. Typically, each state requiring the submission of a Medicaid cost report also requires that an authorized agent of the provider expressly certify that the information and data contained within the submitted cost report is true and correct.

60. This Medicaid patient data is then utilized by individual Medicaid programs to determine the reimbursement to which the facility is entitled,

and the facility receives a proportion of its costs equal to the proportion of Medicaid patients in the facility.

61. Where a provider submits the Medicare cost report to Medicaid, false or incorrect data or information contained in the Medicare cost report necessarily causes the submission of false or incorrect data or information to the state Medicaid program.

62. Where a provider submits the Medicare cost report to Medicaid, the false certification on the Medicare cost report necessarily causes a false certification to Medicaid as well.

63. Where a provider submits a Medicaid cost report that contains the same false or incorrect information contained in the provider's Medicare cost report, false statements and false claims have been made for reimbursement from Medicaid.

64. The United States has been damaged whenever a state Medicaid program has been damaged by defendants submission of false claims and false statements because the United States funds a portion of each state's Medicaid program.

VIII. FALSE CLAIMS AND FALSE STATEMENTS TO MEDICARE AND MEDICAID

65. The Medical Assistance Program ("Medicaid") provides coverage for a wide array of necessary

medical services for the poor and disadvantaged. 14 U.S.C. §§ 1396, 1396D-(a) *et seq.* Since 1965, the Social Security Act, Title XIX has funded Medicaid. The primary purpose of the Medicaid Act was to access to and improvement of the quality of medical care for indigent individuals.

66. While participation in Medicaid is not required, a state choosing to participate in Medicaid must devise a state plan for medical assistance according to Federal guidelines and receive approval of the plan from the United States Department of Health and Human Services ("HHS"). 42 U.S.C. §§ 1396; 42 C.F.R. § 430.10.

67. The Commonwealth of Massachusetts participates in Medicaid, through programs such as Mass. Health, Secure Horizons, as well as D.S.H. carve outs where the Hospital writes off the treatment and claims under the state Medicaid supplement program, and as such, is eligible to receive federal funds under Medicaid.

68. As alleged herein, all defendants engaged in a concerted effort and scheme to maximize reimbursement from various government health care programs, including Medicare, Medicaid and Tricare Champus.

69. These efforts involved the submission to these programs of costs allegedly associated with the care rendered on behalf of their beneficiaries, which they knew were not reimbursable under the rules and regulations governing these programs.

70. These submitted costs constitute false claims under the False Claims Act to the extent the defendants knew, as defined in the False Claims Act, they were not reimbursable under the rules and regulations governing those programs.

71. In the below listed schemes, the Relators detail the major types of false claims and false statements contained within the cost reports prepared and submitted by defendants for their owned and managed hospitals.

72. The examples that follow below are not, by far, an exhaustive list of the false statements and claims allegedly submitted by the defendants. Defendants' false claims are too numerous to catalogue exhaustively in the text of this complaint while remaining in compliance with Fed. R. Civ. P. 8(a).

IX. FALSE CLAIMS AND FALSE STATEMENTS TO MEDICARE AND MEDICAID

73. The defendants, to raise revenue, operate and manage inpatient acute care hospitals under federal and state laws and they are certified to participate in Medicare and Medical Assistance Programs, also known as Medicaid.

74. The Defendants were and are responsible for ensuring that all state and Federal laws, regulations and requirements are complied with at all times as a condition of their participation in the Medicare and Medicaid Programs, and in

order to receive payments by agencies of the United States.

75. The determination of Medicare's share of the provider's total costs is made on the basis of cost to charge ratios and per diem amounts. The inpatient liability for acute care hospitals, for example, is determined by the interim claims submitted by the provider for particular patient discharges during the course of the fiscal year. The claims are summarized on the Provider Statistical and Reimbursement Report and entered on the settlement worksheets as the program liability for inpatient acute care hospital services.

76. HCFA conditions both payment and provider eligibility on the veracity of the statements in the cost report, and HCFA views any false statement contained in a cost report as constituting an abuse of the Medicare program. HCFA considers any cost report containing a false statement to be invalid.

77. The Government conditioned payment of the Medicare/Medicaid claims upon the provider's certification of compliance with the laws and regulations, and the defendants falsely certified to compliance with these laws and submitted claims based on such certifications. The defendants in this action submitted, conspired to submit and/or caused the submission to the United States of false or fraudulent claims for payment under the Medicare Program, Title

XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*; 42 C.F.R. parts 400-1004.

78. The defendants submitted, conspired to submit, and/or caused the submission to the United States of false or fraudulent claims under 42 U.S.C. §§ 1320a-7a, 7b, *et seq.* of the Civil Monetary Penalties Law, as well as under the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801 *et seq.*

79. Defendants instructed, aided, and encouraged and ultimately instituted a systematic and deliberate scheme of knowingly making, using, or causing to be made or used, false and fictitious records and claims, under 31 U.S.C. §§3729(a)(1) and (a)(2), and (a)(7) in order that: (1) the patient appeared to qualify for payment under the Medicare and/or Medicaid programs; (2) the defendant Hospital, its parent corporations, the Medical Home provider maintained their licenses and certifications for participation in the Medicare and/or Medicaid Programs; and (3) false or fraudulent claims would be paid by the United States under false pretenses.

80. As a result of these fraudulent schemes, the defendants knowingly made, used, caused to be made or used, false records or statements in order to cause false or fraudulent claims to be paid or approved by the United States. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these Defendants were not entitled.

81. As a result of its established policies or practices, the defendants owned and managed hospitals have repeatedly falsely certified to the government that its cost reports were a complete statement except as noted."

82. Indeed, the defendants' cost reports were incomplete to the extent that they failed to disclose what the defendants knew, that certain listed in its cost reports were intentionally false.

83. The defendant filed Medicare cost reports that it knew contained untruthful or incorrect claims for reimbursement, contrary to its certifications that the filed cost reports were true and correct to the best of its knowledge.

84. Under these circumstances, the certification by the defendants that each of its filed cost reports is a "correct...statement...except as noted," was knowingly false.

85. This is an action against the named Defendants for implementation of fraudulent schemes to:

(A) submit false claims, records and statements to Medicare and Medicaid;

(B) conspire to have fraudulent claims allowed or paid by the United States;

(C) submit false or fraudulent duplicate claims, records and statements to the United States;

(D) fraudulently and wrongfully alter documents in order to submit claims for payment to Medicare and Medicaid;

(E) fraudulently and wrongfully alter and create documents to permit Defendants to maintain the privilege of participating in the Medicare and Medicaid Programs;

(F) fraudulently and wrongfully divide or fragment services to enable unbundling and "multiple billing" for two or more services which should have been provided in a single category;

(G) Knowingly misrepresent to agencies of the United States the operating structure and staffing of the Hospital and its affiliates by falsely certifying staffing and personnel numbers at fictitious levels in order to raise the level of Diagnosis Related Group (DRG) reimbursement under the quality of care

(H) Knowingly misrepresent coding, then upcoding in order to obtain higher billing rates than what the Defendants were entitled to charge;

(I) Knowingly charge the Government for non-covered services;

(J) Fraudulently change the classification of the care provided in order to obtain Medicare reimbursement;

(K) Obtain kickbacks relating to outside care providers arising from conflicts of interest involving certain Hospital personnel;

(L) Perform add on tests with no medical necessity or physician prescription;

(M) Fraudulently keep admission oximetry test results at acute levels on date of discharge in order obtain Medicare reimbursement ; they would use acute numbers of oximetry results of the date of discharge to justify the need for home oxygen;

(N) Bill indirect care as direct care;

(O) Bill group therapy and treatment sessions as individual therapy and treatment;

(P) Bill outpatient treatment as inpatient treatment, with patients falling within the time frame of the three day window;

(Q) Perform medical services with no medical necessity in order to obtain Medicare reimbursement;

(R) Bill for medical services that were performed in a negligent and careless manner, or were not performed at all.

86. The Defendants conspired to obtain payment for claims which would not otherwise have been paid, and to obtain payment at rates higher than

they would properly have been paid, in schemes to, *inter alia*

(1) wrongfully upgrade, upcode, unbundle, and to fraudulently submit false reports relating to patient medical records and patient eligibility for Medicare and Medicaid coverage;

(2) wrongfully backdate confirming orders of physicians in the absence of physicians instructions, and to change the classification of care in order to obtain Medicare/Medicaid coverage;

(3) wrongfully direct nurses, therapists, lab and hospital personnel to change, back date, alter, replace and upgrade progress notes after services had been alleged to have occurred or after a patient had been discharged in order to fit the patient into a category of patient care for which there was coverage;

(4) wrongfully bill Medicare and/or Medicaid and others for the services based upon these fraudulently created and altered records; and

(5) wrongfully provide false and fictitious financial data relating to the operation of the Hospital and Home Care providers.

87. Each of the Defendants was a party to one or more conspiracies to submit false claims or fraudulent claims to agencies of the United States.

88. Defendants caused the submission of claims containing falsified information, falsified signatures and upcoded and intentionally false and erroneous information in order to obtain Medicare and Medicaid reimbursement.

89. At times relevant to this complaint, and particularly during 1994 through the present, Defendants instructed aided and encouraged and ultimately instituted a systematic and deliberate scheme of knowingly making, using, or causing to be made or used, false and fictitious records so that all these false and fraudulent claims would be paid by the United States.

90. As a result of these fraudulent schemes, the defendants knowingly made, used, caused to be made or used, a false record or statement in order to cause a false or fraudulent claim to be paid or approved by the United States. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

91. Through his job duties, the Relator John C. Karvelas witnessed the fraudulent conduct alleged herein.

X. SPECIFIC ALLEGATIONS – DEFENDANTS' SCHEMES TO DEFRAUD

92. To provide the privacy of patients, including Medicare and Medicaid beneficiaries, the full names of patients of Defendant Melrose-Wakefield Hospital are not provided in this pleading; rather, each is listed generally as "patient," "patients," or "health care recipients." The patients, living and deceased, are individuals who reside or resided in various counties throughout the Commonwealth of Massachusetts.

93. The Relator John C. Karvelas's job responsibilities as a Respiratory Therapist included the administration of life support and respiratory treatments to patients of the defendant Melrose Wakefield Hospital.

94. Respiratory therapy services are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

95. In 1994, Melrose-Wakefield Hospital began to consider a merger with Whidden-Memorial. CEO Richard Quinlan of Melrose-Wakefield Hospital stated Melrose-Wakefield Hospital was merging with Whidden Memorial to gain Medicare patients and their reimbursement.

96. The defendant Melrose-Wakefield Hospital began a cost cutting process in 1994, cutting staff

and consolidating departments to allow the merger to take place.

97. In 1996, 1997, the merger was finalized.

98. The defendant Melrose-Wakefield Hospital and its parent defendants engaged in a systematic effort to take advantage of, exploit and cheat the United States Government by putting together schemes to falsify claims for Medicare and Medicaid reimbursement and put the Hospital and its parent corporations back in the black.

99. The Relator John C. Karvelas, beginning in 1994, observed a number of practices in the Hospital that were in violation of the standards of patient care established by the Federal Government, the Commonwealth of Massachusetts, and the Relator's licensing board, and that, over the course of time, violated the rules of the Medicare and Medicaid accrediting agencies.

100. These violations included the wrongful management in the Hospital from the top down that resulted in understaffing, inadequate patient documentation, and failure to provide quality controls in arterial blood gas (ABG) testing. When controls were not being run, the blood gas test results were erroneous, and reliance on those tests resulted in a threat to patient safety. The care was inferior, and when controls were run and still did not come in, the defendant Hospital would still report these results as bonafide and bill for them.

101. The Plaintiff wrote a letter in 1994 to the Hospital's CEO and President, Richard S. Quinlan, in which he, the Relator John C. Karvelas, delineated the substandard patient-care practices that he had observed, and he suggested alternative procedures.

102. Richard S. Quinlan took no remedial actions. In fact, CEO Quinlan stated at many management meetings in which the Relator's statements were read, that whoever wrote the letters should be terminated.

103. In 1995, the Relator went to the Vice-President for Nursing Services, Sharon O'Connor, and reported how dangerous it was at the Hospital with the under-staffing and with no backup system in place.

104. By 1996, patient care in the Respiratory Therapy Department had deteriorated to the point where ventilators were changed without orders, treatment orders were not carried out, and incident reports were removed from files. These services were billed, but not documented or carried out.

105. The plaintiff Relator John C. Karvelas noted inadequate staffing, inconsistent administration of treatment orders, the absence of blood gas quality control, and inappropriate documentation in the administration of care and treatment of patients throughout the Hospital, as well as the failure to meet regulatory standards which are required for reimbursement by Medicare and

Medicaid. The Hospital was not in compliance with regulatory standards.

106. While still an employee of the Hospital, John Karvelas pointed out to his superiors, all the way up to the president, the inadequate staffing, inconsistent administration of treatment orders, the absence of blood gas quality control, and inappropriate documentation in the administration of care and treatment of patients throughout the Hospital, as well as the failure to meet regulatory standards which are required for reimbursement by Medicare and Medicaid. He repeatedly pointed out to Hospital personnel that the Hospital was not in compliance with regulatory standards and that they were providing substandard care.

107. The Relator took the position that the Hospital could afford better care for these patients, and that the Hospital should have as its goal getting the patients discharged rather than in prolonging their care and their illness.

108. On September 9, 1996, the Relator John C. Karvelas once again complained about the problem with arterial blood gas (ABG) testing machinery, about understaffing and patient neglect, this time to the Vice President of Human Resources for the defendant Hospital, Richard G. Kenny. The Relator John C. Karvelas provided Mr. Kenny with documentary evidence of these problems.

109. The Realtor notified Doctor Ronald P. Sen, who was responsible for the blood gas laboratory, when he, the Realtor, felt he was jeopardizing his license by having ventilators on patients that were coming up codes with so many hours of use service needed.

110. John C. Karvelas additionally informed Mr. Kenny that his, the Realtor's, supervisors had destroyed incident reports regarding medical errors.

111. Mr. Kenny took no actions in response to the reports given to him by the Relator.

112. The Relator John C. Karvelas also complained about directives from his immediate supervisor to complete patient evaluations even if the patients had been discharged or had died. These evaluations were billed at $150.00 each, which included inpatient and outpatient, and which were not reimbursable items, but yet were billed to Medicare and Medicaid. Mr. Karvelas' supervisor in the Respiratory Therapy department threatened Respiratory Therapists with retaliation if they failed to participate in this illegal activity.

113. In September, 1996, the Realtor was directed to go see Doctor William Lilly, the director of the laboratory.

114. In early October 1996, Ms. Hyland-Miller told the Relator that she knew about complaints I had made to the director of the blood gas

laboratory, Dr. Lilly. Within the next few days, Ms. Hylund-Miller, in order to retaliate against me for reporting to her boss that there was no back up system in place, falsely accused me of improperly dispensing medication and not doing a patient evaluation that had been ordered previously after I went to O'Connor about how unsafe it was. I had been to O'Connor in 1995 about how unsafe it was. In December, 1996, the Relator met with Risk Management at the defendant Hospital and again the Hospital failed to take corrective action.

115. The CLIA documents indicate the Hospital knew about the problems in September, 1996. The HCF documents indicate that the Hospital represented to HCFA that it had taken immediate action, but it did not take any action.

116. Because of this failure to take corrective action, the Relator went to Doctor Ronald Sen on January 27, 1997. The Relator Karvelas provided Dr. Sen with quality control logs relating to blood gas testing. Dr. Sen asked Mr. Karvelas to immediately speak to Dr. Sen's superior, Dr. Lilly. Upon examining the logs, Dr. Lilly stated that he could not believe that one of the Relator's supervisors "had been lying to him all that time."

117. In June of 1997 the Relator divulged the fraud to MCAD.

118. In his position as a Respiratory Therapist, Mr. Karvelas' efforts were evaluated on a yearly

basis by the Hospital's Director of Respiratory Care. Between 1982 and 1994, Mr. Karvelas had an exemplary performance appraisal history and had been given service awards over a dozen times by the Hospital.

119. On the 27th day of January, 1997 when the Relator returned to the Respiratory Therapy Department after meeting with Drs. Sen and Lilly, Ms. Hyland-Miller, who had just hung up the telephone receiver, asked him where he'd been. Relator Karvelas described the data that he had collected, his visits with Drs. Sen and Lilly, and the failure of the Hospital to meet patient-care standards. Ms. Hyland-Millar responded: "That's it. You are gone. You are out of here. You're terminated. You no longer work here."

120. Brenda Hyland-Miller called for security personnel, and two of the Hospital's security guards come to the Respiratory Therapy Department and escorted the Realtor through the hallways, past patients, visitors, an staff, and out the Hospital door.

121. In a letter dated January 28, 1997 which was signed by Brenda Hyland-Miller and Richard G. Kenny, the Relator was told that he had been discharged because of "inappropriate behavior...for example, on January 7, 1997, the Hospital learned from a member of a state senator's staff that you had reportedly alleged unsafe conditions at the Hospita"

122. In March, 1997, as a result of reports from John Karvelas, the Department of Public Health released an investigative report on the Hospital's Respiratory Therapy Department. Among other patient-care violations, the report confirmed inadequate staffing, the inconsistent administration of treatment orders, the absence of blood gas quality control, inappropriate documentation, and breach of confidentiality. Accordingly, the Department of Public Health generated a deficiency letter to the defendant Hospital and requested a plan of correction.

123. The plaintiff Relator in July, 1996, reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on the unsafe staffing at the defendant Hospital and the effect it had on patient care - that the workload exceeded the workforce required to meet patient demands, and the care provided did not meet the standards accepted by the medical community or those set forth under the rules and regulations of HCFA.

124. As a further result of Relator John Karvelas' complaints, Ms. Hyland-Miller was forced to resign from the Hospital in early July, 1997. Mr. DiChiara was demoted from Senior Clinician to respiratory therapist. During this same time period, President Quinlan told the Respiratory Therapists that he had "no knowledge' of the patient care problems that had been going on in the Respiratory Therapy department, even though John Karvelas had reported these problems directly to him.

125. The defendants defrauded the Federal Government by engaging in the particular schemes described below.

Scheme A

THE HOSPITAL FRAUDULENTLY MISREPRESENTED STAFFING LEVELS IN ORDER TO OBTAIN A HIGHER RATE OF MEDICARE REIMBURSEMENT.

126. In 1994 through 1997, Melrose-Wakefield Hospital was making an income of $110 million a year through M&C Choice, BCBS, Medicare, Medicaid, regular HMO reimbursement and Mass Health.

127. In order for the defendant Melrose-Wakefield Hospital to qualify for payment under the Medicare program, specific requirements for payment must be met. 42 U.S.C. § 1395 *et seq*; 42 C.F.R. § 400-1004.

128. As noted in paragraphs 11 through 61, Medicare and Medicaid require aaccurate reporting of financial information on costs reports and credit abuses. 42 C.F.R. § 413.20. Under 42 U.S.C. §1320a-7a(a).

129. The defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. The defendant Hospital and Home Care Provider filed claims that were based on codes that the defendants knew would result in greater payments than what an appropriate code

would have provided. 42 U.S.C. §1320a-7a(a)(1)(A).

130. The government pays for quality, and the DRG is calculated using, among other things, the wage index. One of the factors establishing the quality of care is the number of staff under the wage index - the number of employees the hospital is supposed to have under the rules and regulations of the Department of Public Health (DPH) and the Federal Health Care Administration (HCFA), and the number of employees in each and every one of these specialty categories is filed with these administrations.

131. The staffing levels per patient establishes for the hospital the rates it is allowed to charge each of its patients under Medicare and Medicaid, per care rendered, and per diagnosis. HCFA determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge involving inpatient hospital services at a hospital in the United States subject to the prospective payment system, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region.

132. HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year, and determines a regional adjusted prospective payment rate for operating

costs for such discharges in each region, for which payment may be made.

133. As previously noted, 42 CFR § 412.71 provides the formula for the determination of base-year inpatient operating costs, and 42 CFR § 412.72 provides a formula for the modification of base-year costs. 42 CFR § 412.328 provides for updating the hospital specific rate using the base year cost reporting period to determine the cost per discharge.

134. On information and belief, as of 1994, the Hospital decided to significantly cut costs.

135. From approximately 1989 to 1994, Brenda Hyland-Miller was the Hospital's Director of Physical Therapy. In 1994, Brenda Hyland-Miller was promoted and appointed as the Hospital's Director of Rehabilitation Services, which combined Physical Therapy, Speech Pathology, and Respiratory Therapy.

136. In mid-1994, Ms. Hyland-Miller became Mr. Karvelas' direct supervisor. Ms. Hyland-Miller acted under the direction of senior management at Melrose-Wakefield Hospital.

137. Ms. Hyland-Miller's background was with physical therapy and rehabilitation, and, on information and belief, she had no experience, or very little training or exposure to respiratory therapy and critical care.

138. Prior to Hyland-Miller taking over, Steven DiPaola was responsible for the schedule, and he would always assure that there was adequate coverage to meet patient needs.

139. In a cost-containing move, Brenda Hyland-Miller stated to the Respiratory Therapy department that the Hospital was going to downsize. The Hospital did downsize, reducing the staffing levels in the Respiratory Therapy department from 12 full time Respiratory Therapists to 7 full time Respiratory Therapists, and 5 per diem Respiratory Therapists down to one or no per diem Respiratory Therapists. Paul Nuccio, the then-current Hospital Director of Respiratory Therapy, was laid off in 1994 at the same time that Ms Hyland-Miller added his position to her other responsibilities.

140. The consequence of the cuts in staffing was that, at Melrose-Wakefield Hospital, beginning in 1994, the staffing levels certified to the United States Government were make believe. From 1994 into 1997 the Hospital was certifying 12 respiratory therapists when in reality the hospital had only 7 full time respiratory therapists. The Hospital showed a number of employees full time, yet DPH and HCFA showed that these staffing levels were bogus from 1994 through 1997.

141. Through Ms Hyland-Miller's reduction in the Respiratory Therapy Department from approximately 11 to 7 came an increase in workload, specifically the addition of chest

physical therapy, patient evaluations, and related paperwork. The Hospital at the time stated that outside agency Respiratory Therapists would be utilized if there was a need. The authority to bring in outside therapists to meet patient needs was specifically set forth in the Policy and Procedures Manual shown to the Joint Commission on the Accreditation of Hospitals who inspected the Hospital in 1996.

142. The Hospital began with 6 per diems, but, because of the understaffing and the failure to make adjustments by Hyland-Miller to the work load, the per diems chose to resign rather than work under the unsafe conditions. However, from 1994 through February, 1997, when the Massachusetts Department of Public Health conducted an on-site investigation as a result of a complaint filed by the Relator John Karvelas, at most only one per-diem Respiratory Therapist position was ever filled. As a result, there were at most 8 (if one includes the one per diem) full time Respiratory Therapists on the Hospital's staff during this period, despite higher needs due to the workload, and despite the fact that the Hospital was certifying to the Federal Government a full component of 11.8 Respiratory Therapists.

143. The Respiratory Therapist time schedules for 1994 into 1997 serve as documented examples which are representative of the type of false and fictitious reporting of staffing levels at Melrose-Wakefield Hospital during the Relator's involvement with the defendant Hospital. These

documents signed under the penalty of perjury and false statement and submitted to the United States Government certified that there were 11.8 Respiratory Therapists during this period of time.

144. In addition to the Respiratory Therapy department, the staffing numbers in the Medicare and Medicaid filings were make believe throughout the entire hospital, from nursing, to lab, to respiratory, to nuclear medicine, to EKG, to X-ray. All Full Time Employee (FTE's) certifications were make believe and exaggerated in order to calculate a higher rate of reimbursement from Medicare and Medicaid in the negotiated payment system.

145. The future rate of reimbursement, and the future rate for the DRG was established back in 1994 and 1995, and was based in part on the number of staffing personnel that was submitted. The falsely certified staffing levels submitted to the United States Government in 1994 and 1995, upon which claims for reimbursement, right through to the present date, were and presently are, based on the fraudulent numbers contained in the falsely certified staffing levels.

146. The United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

147. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme B

THE DEFENDANTS FALSELY CERTIFIED DEFECTIVE ARTERIAL BLOOD GAS (ABG) EQUIPMENT AND MACHINERY

148. The defendant Hospital performed blood tests with machinery and equipment that was not tested, or up to code, or certified, and did not meet the standards accepted by the medical community, and therefore the blood test results were results that the Hospital could not make a clinical judgment on. 42 CFR § 440.30 et seq and 42 CFR § 493 set forth the conditions under which all laboratories must operate in order to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Under CFR 493.1245 the laboratory must test one sample of control material each eight hours of operation.

149. These sections articulate the finely crafted rules and regulations for patient test management, including procedures for specimen submission and handling, the test records, and the score one

must attain to maintain certification. These regulations provide program compliance and standards for every type of laboratory test, from toxicology, immunology, and serology to parasitology, chemistry and urinalysis. Under CFR 493.1425(b)(3), testing personnel must adhere to the laboratory's quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed. Under CFR 493.1107 Test Records. The laboratory must maintain a record system to ensure reliable identification of patient specimens as they are processed and tested to assure that accurate test results are reported.

150. Because shortness of breath is a subjective symptom, the severity of which is determined by the patient and communicated to the physician, the physician cannot "feel" or measure the degree of shortness of breath. Available to the physician since the late 1980's has been pulse oximetry, a rapid, simple, noninvasive measure of oxygen saturation at the bedside. Oxygen saturation has been termed the "fifth vital sign" and failure to monitor it, in situations where hypoxemia, or oxygen desaturation is considered likely can dangerous to the patient.

151. One of the most important diagnostic tools for respiratory therapists and doctors in determining appropriate care for patients in life and death situations is the arterial blood gases (ABG) test. Direct measurement of blood oxygen level is more precisely performed with an

arterial blood gas (ABG) which is invasive (requiring a potentially painful arterial puncture) and takes a bit longer than oximetry. But an ABG gives much more information than pulse oximetry; besides the partial pressure of oxygen in arterial blood (Pa02) an ABG measures the partial pressure of carbon dioxide (paO)2) the pH, and, depending on the equipment, the oxygen saturation, the met-hemoglobin concentration and the carboxy-hemoglobin concentration (a direct measure of the amount of carbon monoxide in arterial blood - useful in carbon monoxide poisoning and heavy smoking) of arterial blood.

152. The evaluation of shortness of breath and the subsequent risk of respiratory failure is complex but usually involves a detailed history, a physical examination, a chest x-ray, pulmonary function tests (PFT's) - tests that measure variously the static volumes, expiratory flow rates and gas diffusing capacity of the lungs, and possibly some measure of oxygenating ability as with an ABG or pulse oximetry. ABGs are sometimes reported with PFTs.

153. The test is used upon admission to decide whether admission is appropriate, whether oxygen therapy is needed, and whether ventilatory support is necessary. Also, the test is used to determine when a patient is to be weaned off of ventilatory support and also off of oxygen.

154. The ABG test is also used to determine and justify the need for home oxygen expenditures. It is also used to determine the inpatient course of treatment and whether to intevene, to treat, to overtreat (hyperventilate) to under treat, and to manipulate the neurological, cardiac, and metabolic side effects of the treatment chosen. The ABG test results are (one of) the most important factor(s) in deciding the course of treatment and length of. stay for patients being treated at the hospital.

155. Under 42 U.S.C. § 263a, the Hospital "could not solicit or accept materials derived from the human body for laboratory examination or other procedure unless there was in effect for the laboratory a certificate issued..." The certificate would be issued for the laboratory only if the laboratory met certain requirements. The laboratory was accredited if it described in its application the characteristics of the laboratory examinations and other procedures performed by the laboratory, including the number and types of laboratory examinations, the methodologies for laboratory examinations, and the qualifications of the personnel directing the testing. Most importantly the laboratory was required "to provide satisfactory assurances that the laboratory will be operated in accordance with standards issued by the Secretary..." id at 42 U.S.C. § 263a.

156. The laboratory "was required to maintain a quality assurance and quality control program adequate and appropriate for the validity and

reliability of the laboratory, for the validity and reliability of the laboratory examinations and other procedures of the laboratory and to meet requirements relating to the proper collection, transportation, and storage of specimens and the reporting of results." 42 U.S.C. § 263a(f)(1)(A).

157. Prior to the arrival of Ms Hyland-Miller in 1994, in order to validate ABG test results and to ensure appropriate treatment, quality controls were run at the beginning of every 8 hour work shift in each ABG test machine prior to any blood being analyzed.

158. The purpose of ABG validation tests was to ensure that the machines were rurming appropriately and the results that were being reported were accurate. This process ensured that proper clinical judgments could be made. If the ABG test results were inaccurate, then it was a literally a matter of luck and professional instinct as to whether the proper medical decision were made.

159. In April of 1994, Paul Nuccio was the Manager in charge of the Respiratory Therapy Department. He was the Respiratory Therapist with substantive knowledge of the importance of the ABG tests and of Respiratory Therapy treatments in general, and he gave written warning to Tony Dichiara and Melody Rochester for reporting out arterial blood gases that had failed to have controls run. For this reason, the ABG's could not be relied upon for making clinical judgments.

160. In May, 1994, Dichiara and Rochester spoke disparagingly of Nuccio to the Assistant to the Vice President of Nursing, and this was related in an employee satisfaction survey - how Nuccio was supposedly being unfair to these two employees for writing them up relating to the quality control issue.

161. Shortly thereafter in 1994, the Hospital eliminated Nuccio, and one month after the above incident, Nuccio was replaced by Brenda Hyland-Miller.

162. As a result of the increased workload and reduced workforce in the Hospital's Respiratory Therapy Department (as described in Scheme A) many of the therapists were unable to perform all of their duties, including the quality controls on the ABG test machines. In addition, preventative maintenance on these machines was also not done.

163. The Hospital, through Ms. Hyland-Miller, was specifically aware of the problems as set forth in this paragraph. These problems were brought to the Hospital's attention by the Relator John Karvelas, and by Jack Reidy, Charles Beaton, Chuck Raia and Steve DiPiala.

164. The College of American Pathologists (CAP) which inspects and certifies the Hospital laboratory, including the Blood Gas lab, requires by its standards that the Blood Gas machines be maintained appropriately and that quality controls be run every S hours. The CAP

certification is necessary for hospital accreditation and payment under Medicare and Medicaid.

165. Under 42 CFR 493, Melrose-Wakefield falsely certified the satisfactory completion of the tests required under the CFR to gain Medicare and Medicaid funding.

166. Melrose-Wakefield Hospital consistently failed to reach the target value for quantitative tests, or to reach the standards established by definitive or reference methods acceptable for use in the National Reference System for the Clinical Laboratory (NRSCL) by the National Committee for the clinical Laboratory Standards (NCCLS). The defendant presented claims for blood tests that were invalid per CAP, CLIA and JCAHO standards for participation in federal programs for Medicare and Medicaid reimbursement.

167. The defendant Meirose-Wakefield Hospital ignored calibration verification procedures and omitted failed equipment maintenance and function checks. Quality controls were not run on the equipment or the machinery that performed the blood gas testing. The machinery for the testing was out of service, and did not fall within the range of proficiency required for the testing.

168. The membranes on the testing system were blown. The ABG reports and printouts and charts and all reports resulting from the Blood Gas testing were false, and the bills submitted to

Medicare and Medicaid were falsely certified as having been the result of equipment which had been certified and tested.

169. The Government, which paid for admission under a diagnosis related group (DRG) which was based on the ABG reports, paid for the care of patients who did not get what was ordered for them. 'What the patient got was bogus as far as the analysis of arterial blood gases was concerned. The physicians were making medical decisions based on instinct rather than on accurate data.

170. The lab performed approximately 21,000 arterial blood gas tests (ABG's) in the three year period beginning in June, 1994 through April, 1997 at $50.00 per test, and the defendant Melrose-Wakefield Hospital billed Medicare and Medicaid for the costs of the testing on a large percentage of these patients, with each bill certified to Medicare or Medicaid that the ABG laboratory had in fact complied with CAP and CLIA standards. The ABG Laboratory never met CAP or CLIA standards.

171. Life and death decisions were based on these results. After the Relator pointed out the defective testing machinery, the defendant Hospital took no action.

172. Mr. Karvelas had gone to Dr. Lilly originally in September, 1996 after no corrective actions were taken following his meeting earlier that month with Dick Kenney, one of the Hospital's vice

presidents. Mr. Karvelas returned to Dr. Lilly on January 27, 1997 because of the continued failure to correct and because of a specific incident on January 22, 1997 involving an unborn child.

173. Oil January 22, 1997, ABG tests were run on a fetus while in the mother's womb by one of the Hospital's respiratory therapists. No controls were run prior to running the ABG test, in violation of both the Hospital's stated policies and procedures and in violation of the American College of Pathologists' requirements for laboratory accreditation. One of the other respiratory therapists spoke out about his concern that the ABG test result for the fetus was worthless since no controls had been run. The therapist who had not run the controls, and should have, responded by saying: "[expletive] the controls." A subsequent review of the other method of determining fetal distress found that in fact the baby was in distress. This event was very disturbing and indicative of failure to act by the Hospital. That was why the Relator went to Dr Sen, who was the medical director of the Respiratory Therapy department. Dr. Sen told Mr. Karvelas to go directly to Dr. Lilly on January 27, 1997. Dr. Lilly had overall responsibility for the laboratory, and the Relator reported the defective ABG testing to him. Fifteen minutes after John Karvelas spoke to Dr. Lilly, he told his manager, Ms. Hyland-Miller, what he had done, and he was fired.

174. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.201. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. Under 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital filed claims that were based on codes that the defendant knew would result in Greater payments than what an appropriate code would have provided.

175. The Hospital acknowledged that it knew of the problem back in September 1996 when the Relator John C. Karvelas reported it internally, but still the Hospital failed to take corrective action.

176. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme C

THE HOSPITAL WAS NEGLIGENT IN THAT IT PROVIDED INFERIOR CARE, AND FALSELY CERTIFIED TO THE GOVERNMENT THAT PATIENTS WERE RECEIVING APPROPRIATE CARE.

177. The Hospital is responsible for the standard of care of the patients, and the Hospital is bound to protect and promote each patient's safety. The defendant Melrose-Wakefield Hospital created an unsafe and harmful environment for patients and nevertheless billed the Medicare and Medicaid programs for services for those patients who were put at risk.

178. Statutes and regulations governing Medicaid and Medicare clearly require health care providers to meet quality of care standards, and a provider's failure to meet such standards is a ground for exclusion from the program. See 42 U.S.C. § 1320a-7(b)(6)(B) (the Secretary may exclude anyone who furnished patient services "of a quality which fails to meet professionally recognized standards of health care"); id § 1320c-5 (Providers must assure that patient services "will be of a quality which meets professionally recognized standards of health care").

179. Federal regulations for nursing facilities, when addressing quality of care concerns, mandate that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest

practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment of plan of care." 42 CFR § 483.25. 180. Under Medicaid, "Abuse means provider practices that are inconsistent with sound... medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services... that fail to meet professionally recognized standards for health care." 42 C.F.R. § 455.2.

181. The Hospital must take appropriate precautions to provide reasonably safe environment for patients, or is not entitled to Medicaid reimbursement. United States ex rel. Aranda v. Community Psychiatric Curs. of Okla., Inc., 945 F. Supp. 1485 (W.D. Okla. 1996).

182. Under the HCFA Quality of Care Standards, under the Interpretive Guidelines COP for Patients' Rights, § 482.13(c)(2), "The patient has the right to receive care in a safe setting." The intention of the requirement is to "specify that each patient receives care in an environment that a reasonable person would consider to be safe."

183. At Melrose-Wakefield Hospital there was assembly line medicine which did not meet the standards and quality of care accepted by the medical community and set forth under the rules and regulations of HCFA, and this resulted in neglect arising from the inferior care afforded to the patients. The reduced staffing levels noted in Scheme A gave rise to questionable and inferior

quality of care, so that every patient that walked through the door was at risk, and was neglected by the care that was administered in each department. Many Respiratory Therapists spoke up about the severe understaffing and how dangerous the environment was and how the workload exceeded the workforce.

184. Because of the understaffing the Hospital exposed doctors and nurses who were trying to do their jobs to claims of neglect and malpractice. With 37 patients on a floor, and with only two nurses to take care of these patients, when one patient hits the call bell and another patient is having chest pains, the nurse who is responsible cannot get to the other patient because of an emergency, and so the first patient gets out of bed and falls and breaks her leg or hits her head and gets a subdural hematoma and later dies, and the family sues and the hospital blames the nurse and the doctor. Standards not acceptable to the medical community.

185. There was no continuity in care. There was no education or preventive medicine either. Patients were not being medicated for pain, nor were they being kept under observation while the hospital was stipulating and certifying that they were. All during this period of time, Melrose-Wakefield Hospital, in order to gain Medicare and Medicaid reimbursement, was certifying that it was providing a safe environment.

186. The fraudulent certification of staffing levels described in Scheme A severely undermined the consistency in quality of care. Whether it was the ABG lab, in respiratory, or in nuclear medicine, whether it was in nursing, in EKG or in X-ray, physicians' orders were not being followed. The understaffing resulted in treatments that were delayed or not given at all, or even purposely not given.

187. In many instances, even the treatments that were administered were not documented, and when a treatment is not documented, it was not supposed to be billed. But the treatments were billed anyway.

188. Because the Hospital failed to meet JCAHO minimum staffing requirements, very often schedules were set up with 1 Respiratory Therapist on duty, with two non-respiratory staff persons to cover 35 prescription patients, with eight vents, and four trips to cath scan, or occasions with 17 treatments, eight vents, and 5 to 6 new starts with no Respiratory Therapist on duty.

189. After Tony Dichiara took over the scheduling, patients were admitted and then went 12, 24, 36 hours and did not get what they were ordered per physician order, and they were neglected and abused.

190. The Hospital quite often was not even following the union agreement to have 3 people on days. As a result, treatments were missed in the units

and wrong medications were given to patients.

191. Patients were left without treatment for entire days. Pulmonary function testing was not being done as ordered, prescriptions were administered late, and patients were left without prescriptions being administered. Medicines were not charted and patients with multiple prescriptions were given no charting of medicines.

192. A patient on med 5 in severe distress was left with the medications to treat himself. There was no order for self treatment, and the patient was found in severe bronchospasms.

193. A patient was admitted and CPT was ordered. Incentive Spirometry was never started; another patient who was unable to start went into code 99, cardiac arrest.

194. Wrong medications consistently were administered - a patient who was prescribed Atrovent was given Proventil. A patient who was prescribed Proventil was given Tornalate, and a patient who was ordered 1 hour Albuterol updrafts received no treatment at all.

195. Entire shifts passed with patients receiving no treatments being administered and no evaluations being made.

196. On October 30, 1998, the entire Hospital was left unattended, with no physician in house.

197. A patient in the Intensive Care Unit for Cardio Physical Therapy and Incentive Spirometry, with deep breathing exercises four times a day on November 6, 1996 was not started until the morning of November 7.

198. Vent changes were administered to a patient with the wrong concentration of oxygen, and the changes were made with no physician order being written for the changes; the weaning process on the patient was interrupted, and the patient remained intubated longer than he should have been. Because he wasn't getting the breathing treatments, the patient deteriorated and regressed and reached a point of no return and died. This was reported internally to the CEO, to the Risk Manager, to the Vice President of Nursing Service, and to the VP of Human Resources, who" said it wasn't his job. Rather than take corrective action, the Hospital consistently chose to cover up the heglect, abuse and criminal lack of patient care.

199. A patient was left in the operating room table for a half hour because the Respiratory Therapy Department failed to answer pages.

200. Charlie Beaton, who was licensed practical nurse and grandfathered in as a Respiratory Therapist, was dangerously left alone on a schedule with 35 treatments in house with 7 vents running, not including new starts, along with Emergency Room coverage.

201. One patient's cardio-pulmonary therapy was ordered to begin on October 8, 1996, but was begun the following clay, on October 9.

202. For .another patient, Incentive Spirometry was ordered on November 7, 1996 for one hour at 9:30, but the treatment was not started until November 8, 1996 at 8:00 a.m.

203. A patient with treatment ordered at 10:17 a.m. on November 7, 1996, was not begun until 8:30 a.m. on November 8, 1996.

204. Patients that were ordered to be given treatments every 4 hours (which would mean 6 treatments per day, or 24 treatments over a 4 day period) received a total of only 8 treatments over the 4 day period.

205. Patients routinely came in to the Respiratory Therapy Department without evaluations.

206. New starts for respirators were not given, no prescriptions were charted, and patients went on vents with the wrong settings.

207. Patients were left without oxygen during re-intubation procedures.

208. Patients were left 8 hours without peeps. If one is on breathing machine, if you want to prevent atelactasis, or restore functional residual capacity, or improve gas exchange to cut down on oxygen concentration and toxicity, the Respiratory Therapist turns the dial on the

ventilator to increase the end expiratory pressure above atmospheric. It inflates the lung and allows better expansion and functional residual capacity. Patients who didn't get their "peep", aspirated.

209. Entire units were left with no ambu's with masks, causing the patient to suffer neurological deficit secondary to anoxia.

210. Pulmonary fitness testing books were checked three times - "7a,8a 9a" prior to the patient arriving in pulmonary stress , but there was no doctor. Doctor Sen was notified at 7:30 am that there was a patient in stress testing. At 9:15, Dr. Sen arrived, and the patient still was not fully prepped: At 9:40 a.m., the test was finally performed.

211. Patients were put on ventilators with the wrong vent settings, prescriptions were not administered, and vent changes were given without a physician's order.

212. The Relator intervened to prevent a patient from going into cardiac arrest, and when he reported the neglect, he was told by Karen Miller that he had left a syringe on top of a sharps box with a rubber cap on it.

213. In 1996 a patient with a pneumothorax was discharged prematurely. The Relator found him standing outside, after discharge was finalized, and he, the Relator, returned the patient to the floor. Then Robin Burke, the Nurse Manager,

altered the discharge in the computer.

214. John Karvelas discovered that Physical Therapy was documenting in patients' charts that chest physical therapy was not indicated. The Relator and other Respiratory Therapists got called to the floors when patients were drowning in their own secretions.

215. Patients who were Secure Horizons patients were coming in with cardiac arrest and being told, "He's fine, call us in the morning." If the patients had any other insurance, they'd be taken care of.

216. The aforementioned incidents were noted in a very narrow period of time and they present only a small, distinct snapshot of what was happening and address only a handful of patients that were neglected and harmed by the lack of care.

217. If the staff were surveyed, they would attest to the fact that 250, plus 100 to 150 variance reports were filed because the therapists were unable to provide the care that was prescribed. Nurses, doctors and respiratory therapists were filling out incident reports, and these reports were destroyed by Brenda Hyland-Miller and by Tony Dichiara.

218. Kathy Brennan told the Relator to fill out an incident report when the patient noted above was self medicated, and the Relator advised Kathy Brennan that it would serve no purpose,

because Karen Miller was throwing them out. "Don't worry," she said, "I'll document it in patient's chart." So the Relator filled out an. incident report. The report was supposed to go to Risk Management and to QA. (Quality Assurance), but when the Relator followed up by asking QA to see the incident report he had filed, there wasn't one.

219. Melrose-Wakefield destroyed approximately 250 incident reports related to neglect, abuse, medical errors and medical mistakes, even after the patients were dead or discharged. Melrose-Wakefield instilled in the staff that it was all right to alter, fabricate, destroy and remove patient records for the purpose of covering up substandard care, medical malpractice, neglect and abuse.

220. On or about October 30, 1996, when the Relator John Karvelas gave names to QA relating the practitioners filling out reports related to neglect, abuse, medical errors and inferior care, he verified that Brenda Hyland Miller had been destroying the incident reports

221. The above acts of neglect were not unique to Respiratory Therapy. The problem was system-wide stemming from the understaffing and the overwhelming workload.

222. Numerous therapists resigned due to the working conditions - Bill Chu, Ed Pellot, Kim Trappuca and Chuck Rai.

223. Jack Reidy, Brenda Hyland-Miller's predecessor in charge of Respiratory Therapy, resigned because of the wrongful management and unsafe conditions, as well as the failure of the administration to address the issues and tale corrective action.

224. The violations include the wrongful management in the Hospital from the top down that resulted in understaffing, inadequate patient documentation, and failure to provide quality controls in arterial blood gas (ABG) testing, which is listed in more detail in the preceding paragraphs.

225. From July of 1994, substandard care was provided to patients on a regular basis by Tony Dichiara, Melody Rochester, and Karen Mahoney. Brenda Hyland-Miller not only condoned it, but encouraged it by failing to meet regulatory standards in the Respiratory Therapy department related to understaffmg and quality of care.

226. The following incidents are not demonstrably connected to specific Medicare and Medicaid patients, but are symptomatic of the general atmosphere at the Hospital of neglect, abuse and lack of care. In 1994, a 79 year old patient was raped on the Psychological Ward. The Melrose police arrested the man, and the hospital chose to cover it up and not notify DPH, which, if it had been notified, would have discovered how dangerous it was on Medical 6 because of the understaffmg.

227. The defendant Hospital did not provide a safe environment. Jack Karvelas broke up a heroin deal at the hospital when two patients from Med 6 went out to the parking lot and bought drugs. Up to and including the present date, there is an unsafe atmosphere at the hospitals owned by Hallmark. Recently, at Malden Hospital, the OR Supervisor hired a rental truck and picked up a new stretcher that had been delivered and stole it.

228. Tony Dichiara, the Relator's immediate supervisor at Melrose-Wakefield Hospital had a criminal record involving a felony conviction for having sex with a 14 year old boy, to which he had pleaded guilty. The Hospital knew of the criminal record, yet exercised no due diligence and allowed Dichiara to continue in his employment at Melrose-Wakefield in a supervisory capacity as head of the Respiratory Therapy Department. Dichiara was specifically required to disclose this criminal conviction as defined under 42 U.S.C. § 1320a-7(i). OIG recommends that'such an individual "be removed from direct responsibility for, or involvement in, any Federal health care program. The Hospital took no such steps. Paul Nuccio, Brendan Hyland-Miller's predecessor, went to CEO Quinlan and expressed his concerns o f having Dichiara in the hospital as an employee and the legal liability for the actions that Dichiara might take. The hospital did nothing.

229. In 1995, Operating Room nurses filled out incident reports relating to a surgeon, Doctor

Alfano. He handed over a scalpel to an operating room technician and allowed the technician to slice open numerous patients from the chest down to the belly button. The incident reports were filed by nurses regarding this event and the harm that had occurred, but there was a cover up and the families did not know what had happened to their loved ones. Richard Kenny dealt with the situation by taking no disciplinary action against Dr. Alfano on behalf of the hospital. In fact, the Hospital made Alfano a trustee.

230. In 1995, Karen Mahoney - the one per diem Respiratory Therapist described in Scheme A - was on duty and could not be found for over 5 hours while a patient went into a code 99 cardiac arrest. The patient needed breathing treatment, ventilators, blood gases or needed someone to suction the patient. Security searched for Karen Mahoney and finally found her unresponsive, having taken an overdose of Xanax. Richard Kenny stated in September that he had heard about the incident, but he nonetheless failed to address it, and the Hospital covered it up and never notified the families that were exposed.

231. John Karvelas took the position that the Hospital could afford better care for these patients, and that the Hospital should have as its goal getting the patients discharged rather than in prolonging their care, and their illness, as well as their pain and suffering. The Relator on repeated occasions brought the neglect to the attention of Hospital officials and to his

superiors, reporting in 1994, 1995, 1996 and 1997 how dangerous it was with the under-staffing and with no backup system in place. No remedial actions were taken.

232. In fact, the Relator provided Richard Kenny with documentary evidence of these problems, including the fact that his supervisors had destroyed incident reports regarding medical errors and patient neglect. Mr. Kenny took no actions in response to the reports the Relator had given him.

233. The Picker survey was released in 1997. The report indicated that call bells were not being answered and there was no continuity in care and no education for roughly 20% to 25% of the patients admitted under an observations stay and not medicated.

234. The United States Government was paying for appropriate treatment which patients did not receive, per the diagnosis, per the standards and per physician order. And this led to a questionable and suspect consistency in the quality of care. The defendant Hospital and Home Care providers routinely submitted claims for the treatment of patients in substandard conditions. The Hospital created an unsafe and harmful environment for its patients and billed the Medicaid and Medicare program for the care of these patients, in violation of the False Claims Act as if it was a safe enviornment.

235. The Hospital was being wrongfully managed - there was no consistency in the quality of care - from the understaffing to the care that was being afforded to every the patient in the Hospital - and the Relator John Karvelas would not tolerate the coverup of wrongful death, medical malpractice, medical errors and medical mistakes at the hands of a corrupt system and corrupt people.

236. In July, 1997, the Relator reported unsafe staffing at Melrose-Wakefield and the effect it had on patient care - that the workload exceeded the workforce required to meet patient demands - to the Joint Commission on Accreditation of Healthcare.Organizations (JCAHO). 237. Melrose-Wakefield submitted claims for reimbursement, and asserted with the claim for reimbursement that it had supplied the requisite standard of care. Melrose-Wakefield failed to provide a reasonably safe environment for patients whose care was reimbursed by Medicare and/or Medicaid, and the billing for that care was therefore false or fraudulent.

Scheme D

THE HOSPITAL ENGANGED IN A FRAUDULENT SCHEME TO PROVIDE SERVICES THAT WERE NOT MEDICALLY NECESSARY

238. The services provided by the defendant Hospital must meet the following criteria in order for the Federal Government to pay:

a. There must be direct identifiable services provided to an individual patient.

b. The services must be furnished at the direction of a physician because of a specific need.

c. The service must be prescribed to improved the patient's condition in a reasonable amount of time and in a timely manner.

d. The therapy must not be unreasonable in amount, or frequency of duration.

e. The therapy must be supported by the medical record.

239. Under 42 CFR § 424.10 the physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders tests, drugs and treatments, and determines the length of stay. Under 42 CFR § 410.12, the services must be certified as being medically necessary. Sections 1814(a)(2) and 1835(a)(2) of the Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services.

240. Under the same section of the Act, the provider must obtain the required certification and recertification statements of medical necessity and keep them on file for verification by the intermediary, if necessary; and certify, on the appropriate billing form, that the statements

have been obtained and are on file. Claims should be submitted only when appropriate documentation supporst the claims and only when such documentation is maintained in legible form and available for review.

241. Under 42 U.S.C. §1320a-7a(a)(1)(E) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not medically necessary. The defendants presented claims that were for medical or other items or services which the defendants knew, or should have known, were false or fraudulent. 42 U.S.C. §1320a7a(a)(1)(B).

242. A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition. See 42 U.S.C. § 1395y(a)(1)(A). ("no payment may be made under part A or part B for any expenses incurred for items or services which ... are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of the malformed body member") On every HCFA claim form, a physician must certify that the services were medically necessary for the health of the beneficiary.

243. Patients admitted to Melrose-Wakefield Hospital and the Cummings Skilled Nursing Facility at the Hospital did not meet the pre-admission criteria relating to medical necessity,

and care given by the Physical Therapy department was not medically necessary.

244. The Relator in 1994, 1995 was asked to do in-service instruction to MelroseWakefield nurses in the Home Care Unit relating to Melrose-Wakefield Home Care. He did the in service on the usages of oximetry, which is a hands on treatment. He had the opportunity to see the medical records of the patients, and noted that the patients did not have orders from a physician to do the oximetry.

245. An add-on test is a lab or urine test that is ordered, and with that sample, other tests are run off that sample. If there isn't a prescription, which most often provides the basis for determining medical necessity, the test should not be performed. A physician is required to prescribe the test, and a physician is supposed to be the one who orders CBC and add-on tests. At the defendant Hospital, the add-on tests were routinely administered with no medical necessity, no prescription, and no certificate of need. The physicians at the defendant Hospital never gave orders for the add-on tests to be performed.

246. The Relator John C. Karvelas, as a Respiratory Therapist, on several instances called the doctors to obtain the prescriptions for PFT tests and Stress tests, but the doctors did not send them. Nonetheless, the Hospital went ahead with the add-on tests and billed Medicare. These add-on tests were occurring with PFT and pulmonary

stress tests, and the same was happening in the laboratory with the add-on tests.

247. Patients were ordered for two weeks of therapy, with breathing treatments, chest P.T., physical and occupational therapy at the Cununings SNF unit at the defendant Hospital, but they didn't need it and there was no prescription for the testing and no medical necessity. The Relator John Karvelas did pulmonary function tests and pulmonary stress tests on patients from 1989 through 1997 where there was no prescription, and thus no medical necessity indicated. The patients would go through admitting, and show up with a computer printout that had name, date, and medical record numbers with no diagnosis and no prescription for testing, but the Relator, along with other Respiratory Therapists, was ordered to perform the tests that were booked, and then to contact the doctor's office for the prescription following the test. The doctors would never send the prescription.

248. In 1995, the Relator discovered that the lab personnel were complaining that the doctors were sending patients in for lab tests and later requesting add-on tests, but failing to provide prescriptions.

249. Treatments were milked for prolonged periods of time - treatments that the patients didn't need, such as breathing treatments, Incentive Spirometry, chest physical therapy, ambulation, range of motion and speech therapy.

250. The defendant Hospital also screened every patient who came in, and if they came in with a history of any type of old treatment, even if that diagnosis was five years old, the nursing home physical therapist would use this old history of treatment to justify the need for present therapy.

251. The Cummings SNF unit at the defendant Hospital would increase the mods - a mod is a type of calculation to determine the total number of therapy hours that would be reimbursed by the insurance company or by Medicare - and say that BCBS gave this number of Mods and that Medicare should give the same. The defendant inflated the numbers of mods beyond which were reimbursable under the system.

252. The Cummings SNF unit at the defendant Hospital provided care that was not clinically or medically indicated. If a patient had the miniscule amount of history related to pulmonary, then he or she would be placed on therapy for 100 days as long as the government would reimburse.

253. At the Cummings SNF unit at the defendant Hospital, the physical therapists and the occupational therapists used terms such as "decrease in function" in order to justify a "medical need."

254. The therapy did not improve the patients' condition in a reasonable amount of time. The therapy was not reasonable in amount, or in

frequency of duration, and the therapy was not supported by the medical record.

255. The frequency of therapy was unrealistic and the goals that the Cummings SNF unit at the defendant Hospital set were also unrealistic. Physical Therapy in the Cummings SNF unit at the defendant Hospital set up false or unrealistic goals that could never be met, and the frequency of administering the therapy was increased to levels that were not medically necessary. Patients were not being assessed, evaluated, or reassessed to determine if the patients were achieving the goals.

256. The Defendant Hospital knew the patient was never going to reach that goal and the only reason the Physical Therapy or the Occupational Therapy was prescribed was in order for the Hospital to collect Medicare or Medicaid reimbursement for that particular therapy.

257. If, for example,, a patient had a severe, life threatening stroke - or even when the patient was on Hospice with a terminal illness such as brain cancer - and the only immediate prescription should have been to make the patient comfortable at Optimum Health, the unit at the defendant Hospital set an unreachable goal - to walk a mile - and they'd prescribe a service although the patient was never going to reach that goal.

258. The part A Floor of Optimum, at Wingate, and at all of the Cummings SNF unit at the defendant

Hospital was where the patient would get the therapy, and the Government would reimburse for it as long as the patient did not go over 100 days. Then, when the patients reached the 100 day total, (with the exception of the Cummings SNF unit) and the Government would no longer pay for further treatment, suddenly it was declared that the patient had met his or her goals, and the group sessions were ended, and the patient was transferred off Part A and down to the Part B floor, where they would receive only nursing care.

259. The Physical Therapists and Respiratory Therapists would do the screens on patients and 99% would be placed on Respiratory or Physical Therapy when it was not medically indicated.

260. Therapy also was ordered on a past medical history that was not related to the present admission, and was therefore not medically necessary. Patients who had a past medical history, for example, of Chronic Obstructive Pulmonary Disease, (COPD) or Asthma, automatically would be placed on therapy even at a time when there was no need or medical necessity for the therapy.

261. Patients had pulmonary function tests (PFT's), Stress tests, and arterial blood gas tests (ABG's) when there were no prescriptions far them. Medicare should not have been billed, for there were no Physician Certifications obtained on these patients. But Medicare was billed. Medicare was billed without the tests being

accompanied by a certificate of medical need.

262. Another aspect of medical necessity relates to patient evaluations. The Relator objected to the directives from his immediate supervisor, Anthony Dichiara, to complete patient evaluations even if the patients had been discharged or had died. These evaluations were billed at $150.00 each, and they included inpatient and outpatient, which were not reimbursable items, but yet were billed. Dichiara threatened the Relator and the other Respiratory Therapists with retaliation if they failed to participate in this illegal activity.

263. The DPH and HCFA investigations serve as documented examples representative of the type of unnecessary medical services that were not documented, but yet were billed, at Melrose-Wakefield Hospital during the Relator's involvement with the defendant hospital.

264. Over a period of two and one half years, 66,000 treatments were billed. 20% of these treatements were billed without documentation.

265. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme E

THE HOSPITAL SYSTEMATICALLY AND FRAUDULENTLY UPCODED PATIENTS' DIAGNOSIS RELATED GROUPS (DRG'S) IN ORDER TO FIT THE PATIENT INTO A DIAGNOSIS WITH A HIGHER MEDICARE REIMBUIISEMENT.

266. "Upcoding" reflects the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient. The ealth Insurance Portability and Accountability Act of 1996 added another civil monetary penalty to the OIG's sanction authorities for upcoding violations. See 42 U.S.C. § 1320a7a(a)(1)(A).

267. The defendant Hospital upcoded diagnoses so that it could bill the patient and obtain Medicare reimbursement at a diagnosis related group (DRG) with higher codes, and thus at a higher rate of reimbursement.

268. In violation of 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital knowingly presented claims that were based on codes that the defendant Hospital knew would result in greater payments to the Hospital than the code applicable to the item or service actually would have provided.

269. The hospital was involved in creeping upcoding. reeping means that, if there is a past medical history, but this past medical history is not the reason for the current admission, the Hospital or

Nursing Care Facility would use the diagnoses from past admissions on the current admission.

270. Medicare requires accurate reporting of financial. information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed, and, under 42 U.S.C. §1320a-7a(a)(I)(B) which the defendants knew, or should have known, were false or fraudulent.

271. As noted earlier, a hospital is paid a specified amount for each Medicare qualified inpatient it treats.

272. HCFA has established Diagnosis Related Groups ("DRGs") which govern the payment uncle the Medicare Program to hospitals for in-patient treatment of Medicare beneficiaries.

273. Applicable provisions of 42 CFR, Chapter IV, Subpart D, and other applicable federal statutes, provide for payments to hospitals based upon the codification of an in-patient discharge and an appropriate weighing factor that reflects the estimated relative cost of hospital rexources used in treating the patient. Section 412.60(c)(2) provices that "(e)ach discharge will be assigned to only one DRG... regardless of the number of conditions treated or services furnished during the patient's stay."

274. The Medicare Catastrophic coverage Act of 1988 mandates Medicare providers to conduct "diagnostic coding" using the International Classification of Diseases (ICD-9) for each procedure, sevice or supply furnished by the provider to Medicare Part B beneficiaries.

275. ICD-9 is designed for, among other things, the indexing of medical records by disease. ICD-9 is a classification system that arranges diseases and injuries into groups according to established criteria. The ICD-9 code selected for a particular in-patient dictates the appropriate DRG section to be utilized in billing the Medicare Program.

276. The hospital is charged with the responsibility of assigning the correct ICD-9 Code to an in-patient, which is based upon that patient's "Discharge Summary" or "Principal Diagnosis."

277. The Principal Diagnosis is determined by the patient's primary physician who documents the Principal Diagnosis and other "secondary" diagnoses and the Discharge Summary on the patient's medical record. The hospital uses the Discharge Summary and the Principal Diagnosis to determine the correct ICD-9 code for each patient.

278. Medicare pays different reimbursement rates based upon the DRG section used. Accordingly, the determination by the hospital of the DRG section to be used for a particular inpatient dictates the reimbursement the hospital will receive for that patient.

279. The ICD-9 contains a Tabular List, which consists of a numeric listing of diagnostic codes and descriptions consisting of 17 chapters that classify diseases and injuries. Chapter 8 of the Tabular List covers Diseases of the Respiratory System.

280. ICD-9 codes 480 and 481 cover viral pneumonia and pneumococcal pneumonia. Each specified type of bacterial pneumonia is assigned a separate diagnostic code.

281. ICD-9 code 482.89 covers specified types of bacterial pneumonia that are not included elsewhere in codes 480 through 487. ICD-9 code 482.89 is to be used by a Medicare provider only in circumstances where the patient suffers from a strain of bacterial pneumonia that has been specifically identified by the health care professional, but such starin does not have an individual corresponding ICD-9 diagnostic code.

282. If ICD-9 code 482.89 is used, the corresponding DG section is DRG 79. If the health care professional specifically identifies the strain of bacterial pneumonia, and it is a strain listed in ICD-9 codes 480 through 487, then the corresponding DRG section would be DRG 89.

283. For 1994, the nationwide average reimbursement rate for DRG 79 was $6712.09, while the average reimbursement rate for DRG 89 was $4291.55. Therefore, on average, a edicare provider received $2420.54 more in reimbursement per claim using ICD-9 code

482.89 - - and DRG 79 -- than if it used DRG 89.

284. Because the most common types of bacterial pneumonia are enumerated in ICD-9 codes 480 through 487, it should be uncommon for a hospital to use ICD-9 code 482.89.

285. At the defendant Melrose-Wakefield Hospital, the diagnosis codes for respiratory patients were routinely upcoded to DRG 79 when the patient was suffering from viral pneumonia. The Hospital upcoded to obtain the higher Medicare reimbursement on a pneumonia DRG. The Hospital or Nursing Care Facility would diagnose a respiratory infection, which was not supported by the medical records, but which was Medicare reimbursable at a higher rate, when the actual diagnosis was a lung inflammation.

286. Bacterial and viral flu symptoms were commonly and systematically reported as pneumonia to obtain the higher reimbursement.

287. Furthermore, with other diagnoses as well, the defendant Hospital upcoded diagnoses to obtain the higher reimbursements. The Hospital routinely upcoded to DRG 014 (a stroke) from what was actually TIA. If a patient came in with slurred speech or was nauseous, it was determined the patient was having a stroke septicemia, when in fact what the patient really was having was a trans ischemic attack, (TIA), or a lack of perfusion to an area of the brain. The stroke DRG was Medicare reimbursable at a higher rate than a trans ischemic attack.

288. The Hospital routinely upcoded DRG 015 and Septicemia, septicemia vs. Urinary tract infection DRG 416 v 320. Septicemia is a blood infection versus urinary tract infection is in the bladder or kidney.

289. The Hospital routinely upcoded DRG 416 versus kidney stones or urinary tract infection, (DRG 320), each to a diagnosis code that was Medicare reimbursable at a higher rate.

290. The Hospital also miscoded DRG 296 nutritional and metabolic disorder versus DRG 182 gastroenteritis, esophagitis and digestive disorders, when patients had nutritional or metabolic disorders like kidney or liver failure versus inflammation of a bowel, or inflammation of the esophagus.

291. The defendant Hospital upcoded to respiratory failure as principal diagnosis, going from DRG 475 to DRG 127.

292. The Hospital inaccurately coded secondary diagnosis as complications or comorbidities exceeding a threshold for cases with a DRG CC pair examples DRG 174 GI hemorrhage with CC vs 175 GI hemorrhage without CC.

293. The most pernicious conduct in upcoding stemmed from neglect. If a patient was admitted with a viral DRG, and then for two days the patient received very little of the care that was prescribed, when the patient's condition worsened, the patient then would be

upcoded to respiratory failure because the Hospital determined it could get a better rate of reimbursement than one receives for viral.

294. Furthermore, when the patient did not receive the care as ordered, and was neglected for days on end, and then there was a cardiac arrest, or if the patient went into respiratory failure due to lack of care because of inadequate staffing compared to that which the Hospital was supposed to have, the patient would develop a secondary condition due to lack of care stemming from thc failure to intervene or to treat, or to negligently treat because of the malfunctioning arterial blood gas (ABG's) tests. The regression due to lack of care and ending up on a vent was upcoding. In effect, the defendant Hospital created a scheme to raise revenues b billing for services that were not billable items.

295. The defendant Hospital stated in 1994 that patients were not dying of pneumonia and stated that it was a billing error, and that they, the patients, had actually died of cancer, and that the pneumonia diagnosis was a billing error. This shows creeping and upcoding to DRG 79/89 and also DRG 475 Respiratory System diagnosis with Ventilator support. This too was done so the defendant Melrose-Wakefield Hospital would receive a higher rate of reimbursement under the higher DRG. When the defendant Hospital claimed this "billing error," it never refunded or returned the money to the Federal Government that it had received from Medicare under the pneumonia diagnoses.

296. Patients didn't get the care the Hospital represented as having been provided, and, as a result of the neglect, the patients developed whopping pneumonia and atelactasis, or lung collapse.

297. Beginning in 1990, the hospital's admitting officers asked patients every aspect of past medical history, and then they included the past medical history on the admission sheets, even though the admission at the time was not related to the past history. The coding or DRG reflected the past medical history, like pneumonia, diabetes, COPD, myocardial infarction, or stroke, when the true diagnosis was shortness of breath or chest pain from angina.

298. The death certificates at DPH validated the documentation of upcoding that was being submitted to Medicare and Medicaid.

299. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which the defendants were not entitled.

300. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme E

THE HOSPITAL FRAUDULENTLY ENGAGED IN DOUBLE BILLING, OVERCHARGING, AND "CREATIVE ACCOUNTING"

301. The ER doctors or the primary care physician at the Hospital would read an X-ray and charge for that reading. Then, without any request by a physician to have the X-ray reinterpreted, or without any medical necessity in the records, a radiologist would read the same film and duplicate the charge for that reading without changing the course of treatment or admission of the patient after the fact.

302. If a patient was admitted into the Intensive Care Unit, the charges would get picked up under the treatment received in the Intensive Care Unit. The Hospital made it a practice to double bill for "add-ons" - for services that already were included in one bill, and put down again in another bill.

Scheme F

THE HOSPITAL FRAUDULENTLY ENGAGED IN DOUBLE BILLING, OVERCHARGING, AND "CREATIVE ACCOUNTING"

303. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. The defendant Hospital knowingly filed improper claims violating 42 U.S.C. §1320a-7a(a)(1)(A) in that it presented

claims for medical items or service that it knew were not provided as claimed. And violating 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital filed claims that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided. The defendant violated 42 U.S.C. § 1320a-7a(a)(1)(B) in that it presented claims that were for medical or other items or services that the defendant knew, or should have known, were false or fraudulent.

304. The readings of X-rays were billed for interpretation after the patient had been discharged, or after the patient was dead, when the reading was redundant and inappropriate because it did not effect the course of treatment nor did it constitute patient care that was medically necessary. Some of the readings (or interpretations) were done after a patient had been discharged.

305. Radiological interpretation of X-rays was performed days after discharge or admission, and no consult was called in for that interpretation. The X-rays were already interpreted by the primary and or the emergency room physician. The radiologists were not on duty from approximately 8 p.m. to 7 a.m. the following morning on a daily basis, and the only time they would do an interpretation was on CAT scans that were transmitted over telephone to their residence. The course of treatment was not changed by that interpretation.

306. Pulmonary Function Tests and Pulmonary Stress Tests would lie around for days waiting for the pulmonologist to do the interpretation, but they would never show up and interpret the test. Doctor Sen ultimately would do the interpretation, but the other Doctor would also submit the claim for the interpretation, resulting in a double billing.

307. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

308. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme G

THE HOSPITAL FRAUDULENTLY UNBUNDLED CHARGES AND BILLED TESTS SEPARATELY

309. In running blood tests, the tests were performed on automated equipment, and the lab received twenty results from one test, and the results were given in a read out on a panel.

310. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed.

311. In the Deficit Reduction Act of 1984, congress ordered the Secretary to establish a payment system for outpatient laboratory tests based on a fee schedule. 42 U.S.C. § 1395(h). the statute required the Secretary to establish fee schedules for outpaitnent laboratory tests performed by hospital laboratories. Congress further instructed the Secretary to determine the amount of payment for bills submitted by any entity in one of two ways: (1) on the basis of the appropriate fee schedule by paying 80 percent of the lesser of "the amount determined under such fee schedule, the limitation amount for that test ... or the amount of the charges billed for the test:" or (2) "on the basis of a negotiated rate" by paying 100% of the rate. 42 U.S.C. § 1395(a).

312. The defendant Hospital routinely added medically unnecessary tests to panels it performed on automated machines, then billed the health care programs separately for the tests, which physicians had not specifically ordered. The Defendants routinely billed for additional indices which were not ordered by physicians and were not medically necessary.

313. The lab performs one blood test. When the blood is put in the machine in the lab, all these results spit out on an automated machine - amylase, creatinine, triglicerides, magnesium, gluteramyl, transerease, Gamma high density lipoprotein (HDL) thyroxine, Iron, T2 uptake, Iron binding capacity, Lipid Panel, Thyroid panel, ammonia, Lipase, acid phosphase, lactate, cholinesterase, glucose, bile acides, apoliprotein.

314. A blood test, the one test, also would give a panel read out of the results of the Complete Blood Count (CBC), which includes white blood cells (WBC) red blood cells (RBC) hemoglobin (HGB) hemocrit (HCT) MCH, and MCHC. The blood tests also produced electrolytes: Na, K, CL, C02, Anion, GAP, Glucose, Creatinine, Albumin, Bilirubin Total and Direct. Cardiac Enzymes, LDH, CPK, and Triglycerides.

315. All of these results came from one machine, and one test, and the usual charge for the use of this equipment and the printout of the results was a charge in the total amount of $10 for the test.

316. The Hospital unbundled the panels and billed separately each result in order to gain a higher rate of reimbursement. The laboratory chemistry tests and hematology tests were unbundled and billed as separate tests for more money from Medicare and Medicaid. 317. Furthermore, when the Respiratory Therapist gave a patient the Pulmonary Function Test, the Hospital would learn, from the one test, the Functional Residual Capacity (FRC), Maximum

Breathing Capacity (MMV), and the Forced Vital Capacity (FVC). This unbundling also involved outpatients who had pulmonary function tests (PFT's) and Stress test admissions after X-rays, Labs, or oncology visits.

318. All these results of the Pulmonary Function Test also were unbundled, and billed as separate tests, for more money from Medicare and Medicaid.

319. Pulmonary stress tests, which provided a determination of V02 Oxygen consumption and C02 production before and after broncho dilator, as well as Oximetry before and after exercise, were unbundled and billed separately.

320. The laboratory chemistry tests and hematology tests also were unbundled.

321. All of the aforesaid results came from a single test, whether blood, or stress, or pulmonary function, and the results of these tests all were unbundled in order to gain an exponentially higher rate of reimbursement from Medicare and Medicaid. The additional indices, which are generated automatically by laboratory machinery at no extra cost to the laboratory, were mere manipulations of the results of tests already included in a complete blood count. These test results were not medically justified.

322. Melrose-Wakefield Hospital knew not to unbundle yet it did it with every single patient.

323. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

324. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme H

PATIENTS OF THE HOSPITAL WERE FRAUDULENTLY REFERRED FOR HOME CARE OXYGEN BY USING NUMBERS AT ACUTE STATE OF ILLNESS RATHER THAN AT BASELINE ON DATE OF DISCHARGE

325. The blood oxygen level at discharge is used to determine medical necessity under Medicare and Medicaid for reimbursement by the Government for equipment prescribed by the Hospital at discharge.

326. On the date of discharge, if the patient's blood oxygen saturation level is not below a certain percentage, the patient does not meet the criteria for medical necessity and Medicare will not pay for the oxygen equipment.

327. From 1994 through 1997, Anthony Dichiara, Melody Rochester and Karen Mahoney were using acute numbers of oximetry and ABG's that were bogus in order to justify the need for home oxygen. Without the acute numbers, the Hospital would not have met the medical necessity requirements, and so the Hospital provided numbers to gain reimbursement from Medicare and Medicaid for the home care company medical home providers.

328. Melrose-Wakefield Hospital referred patients to home care and oxygen with saturation and arterial blood gas (ABG) levels that were not at the standard baseline which would allow Medicare to pay for the oxygen, but the Hospital obtained the Medicare and Medicaid reimbursements by setting up a fraudulent scheme of, misrepresentation. MelroseWakefield Hospital used the oxygen saturation numbers and the arterial blood gas (ABG) numbers at the acute level when the patient was admitted. Then, when the patient was discharged, although the baseline oxygen saturation numbers had improved to a level which would allow the patient to be discharged, (and which would not allow for Medicare reimbursement) the Hospital sent the patients to outside home care providers and listed the oxygen saturation numbers for which the patient had been tested on admission, when the oxygen saturation levels were at the acute level.

329. Under 42 CFR § 409.27 any oxygen respiratory therapy services required prescription by a

physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. Under 42 CFR § 409.14 Medicare would pay for the appliance only if it was ordinarily furnished by the hospital to inpatients.

330. Under 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital knowingly filed improper claims in that it presented claims for medical items or service that it knew were not provided as claimed. Violating the same section of the U.S. Code, the defendant Hospital presented claims that were for items or services that the defendant knew were not medically necessary 42 U.S.C. § 1320a-7a(a)(1)(E), and presented claims that were for medical or other items or services that the defendant knew, or should have known, were false or fraudulent. 42 U.S.C. §1320a-7a(a)(1)(B).

331. A Trustee of the Defendant Melrose-Wakefield Hospital donated millions of dollars to the Hospital. She became a patient with a respiratory problem, and she felt it would be beneficial to have oxygen at home to relieve some discomfort. If the saturation baseline number is at 85% or lower, the patient qualifies for home oxygen under Medicare. The Trustee/Patient's level was higher, and therefore, she did not qualify for an oxygen concentrator at home. She never desaturated, and her oxygen levels never dropped, and she knew that she didn't qualify because her

saturation levels were not at the level where she would merit Medicare paying for a Home 02 concentrator.

332. In approximately September of 1994, the Relator and other Respiratory Therapists received a call from the administration of the hospital, and the Hospital administration instructed the Relator and others in the Respiratory Therapy department to do whatever they had to do no matter what to get the trustee/patient qualified for home oxygen so that Medicare would pay for it.. The trustee/patient billed Medicare for over three years for oxygen where there was no medical necessity because the defendant Hospital had requested that the Trustee/Patient's Oximetry results be falsified to the need for home oxygen. The results were bogus in order to get Medicare to pay for the oxygen at the Trustee/Patient's home. Employees of the defendant Hospital falsified these Oximetry results to get the physician to write a prescription for home oxygen even though the patient did not qualify for it. The administration falsified the numbers to allow her to qualify. On January 26, 1997, the Trustee of the Hospital admitted to the Relator that the results were falsified.

333. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

334. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme I

THE HOSPITAL FRAUDUEENTUY CILAIMED THAT INDIRECT CARE WAS DIRECT CARE

335. Medicare pays for direct care, it doesn't pay for indirect care. Indirect care is paper work or getting supplies; direct care is direct patient contact. The SNF unit is where this matters.

336. If a Doctor or care provider attended a patient, or a nurse attended, and all the care provider did was review the patient's chart, and checked off the visit on the chart as a review of the patient's chart, the hospital listed the visit as direct care. A review of a chart in fact is indirect care, and thus should not have been a Medicare reimbursable activity.

337. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed.

338. The defendant Melrose-Wakefield Hospital billed as if everything was direct care. While a portion of most patient visits included time that was indirect care, this time was always billed as direct care.

339. The Hospital billed for the Cununings Skilled Nursing Facility (SNF) care as if it were all direct care, when much of the care was indirect.

340. The charts for patients at Cumming's Rehabilitation receiving physical therapy, occupational therapy, speech therapy and respiratory therapy were not documented as direct or indirect, so all the care that was given was billed as direct whether it was direct care or not.

341. The flow sheets for respiratory therapy were instituted in September, 1995. It was Brenda Hyland-Miller and Dichiara who came up with a $150 dollar charge for an assessment on the flow sheet, and this was not Medicare or Medicaid reimbursable or billable.

342. These flow sheets were used from 1995 through 2040 in Cummings Rehabilitation, and they do not differentiate between direct care versus indirect care, and everything was billed as direct care.

343. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

344. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme J

THE HOSPITAL FRAUDULENTLY BILLED MEDICARE FOR MEDICAL EQUIPMENT AND FRAUDULENTLY CHARGED PATIENTS FOR NON-COVERED SERVICES AND NON-- MEDICALLY INDICATED, UNALLOWABLE AND UNNECESSARY COSTS

345. Medicare will not pay for durable medical equipment or supply items unless a Certificate of Medical Necessity is properly completed. Under 42 CFR § 409.14 Medicare pays for appliances and equipment as inpatient hospital or inpatient CAH services only if they are ordinarily furnished by the hospital or CAH to inpatients.

346. If the physician does not personally complete the medical necessity justification for the durable medical equipment, the equipment cannot be prescribed. The certificate of medical necessity cannot be completed by a physician who had not personally and professionally known the patient.

347. Medicare requires accurate reporting of financial information on cost reports and credit balances.

42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. The defendants presented claims that were for items or services that the defendants knew were not medically necessary under § 1320a-7a(a)(1)(B).

348. Cummings Rehab claimed ancillary medical supplies such as dietary, administrative and general costs that were mis-classified for higher or unallowable reimbursement.

349. The Hospital charged patients for non-covered services and, in effect, billed the Government for these services by entering the service under an erroneous code, in violation of 42 C.F.R. §411.404; 42 C.F.R. §489.32. The Hospital used a "creative" billing practice to charge the Government for VO2, C02, and oximetry, which were not billable items.

350. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. §413.20. Under 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital knowingly filed improper claims in that it presented claims for medical items or service that it knew were not provided as, claimed, or as ordered, or without prescription. Violating the same section of the U.S. Code, the defendant Hospital presented claims that were for items or services that the defendant knew were not medically necessary [42 U.S.C. §1320a-7a(a)(1)(E),] and

presented claims that were for medical or other items or services that the defendant knew, or should have known, were false or fraudulent. 42 U.S.C. §1320a-7a(a)(1)(B), and that were based on codes that the defendant Hospital knew would result in greater payments than what an appropriate code would have provided 42 U.S.C. §1320a-7a(a)(1)(A).

351. The Hospital used the BIPAP respirator to gain referrals from MHP and Lincare, then billed it to Medicare, and justified the need by changing the diagnosis to sleep apnea, which is covered, while the true diagnosis was respiratory failure. The BIPAP unit was not approved by HCFA or by the FDA for use in treatment of respiratory failure. The equipment is not a reimbursable piece of equipment unless the patient has the diagnosis of sleep apnea.

352. A bronco dilator is used in asthma type respiratory therapy. For the PFT's the Relator John C. Karvelas and the Respiratory Therapists were instructed to give the broncho dilator whether it was indicated or not, and the respiratory unit submitted charges to Medicare and Medicaid for reimbursement for the broncho dilators.

353. The Hospital billed for a suction tube that wasn't being used, nor was it a billable item, yet the hospital entered the suction tube under an erroneous code and billed it. The hospital billed for Emerson chest tube suction oxygen when these items were not being used, yet claims were

submitted.

354. Beginning in the spring of 1995, Brenda Hyland-Miller and Tony Dichiara came up with the idea of providing inhaler bronchodilator therapy on patients who were on ventilators, and these claims were submitted under hand held nebulizer therapy, even though the charge was submitted through the pharmacy and the charges were submitted when only two puffs were given.

355. Blood pressure, temperature, and oximetry are all vital signs tests, and are not billable or reimbursable items under Medicare and Medicaid. The Relator and the Respiratory Therapy Department did 60 to 70 oximetry procedures per day and the defendant Melrose-Wakefield Hospital billed Medicare for the oximetry tests and was reimbursed for the tests.

356. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

357. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme K

THE HOSPITAL FRAUDULENTLY LISTED PATIENTS AS DISCHARGED RATHER THAN AS TRANSFERRED

358. Under Medicare Choice and Medicaid, which all are diagnosis related group (DRG) based payment systems, a hospital receives a different reimbursement when a patient is transferred from when a patient is discharged. See 42 CFR § 412.4; Medicare Hospital Manual 415.8.

359. The Defendants received a higher rate of payment under Medicare when the DRG was discharge rather than transfer.

360. For a transfer, the transferring hospital receives twice the per diem payment, (the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls) for the first day of the stay and the per diem for every following day up to the full DRG. Cost outliers would-be allowed, but no day outliers. The receiving hospital receives a DRG payment. For a discharge, both hospitals receive a DRG payment.

361. An inpatient is considered to be discharged if the patient is formally released from the hospital, dies in the hospital, or is transferred to a PPS-excluded hospital or distinct part unit. 42 CFR § 412.4.

362. An inpatient is considered transferred if the patient: a) is moved from one PPS hospital area or unit to another; b) is moved from one PPS hospital to another; c) is considered a "qualified discharge"; or d) is moved to hospital whose first PPS cost reporting period has not begun.

363. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed.

364. The defendant Melrose-Wakefield Hospital engaged in a pattern and practice of falsely and fictitiously billing of transfers as discharges in order to obtain a higher rate of Medicare reimbursement.

365. The defendant Hospital filed claims that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided. 42 U.S.C. § 1320a-7a(a)(1)(A).

366. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these, defendants were not entitled.

367. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for

creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme L

THE HOSPITAL FRAUDULENTLY ASSIGNED PATIENTS FOR TESTING AND THERAPY OUTSIDE THE 72 HOUR WINDOW BEFORE ADMISSION OR AFTER DISCHARGE IN ORDER TO GET MEDICARE COVERAGE

368. If a test or a particular therapy is prescribed within a window of 72 hours before admission, or during admission while the patient is in the hospital, or within 72 hours after discharge, then the test or therapy is not covered for reimbursement under Medicare or Medicaid. See 42 CFR §412.4 et seq.

369. Patients were brought in to physical therapy, respiratory therapy, oncology or outpatient services and fell within this 3 day window, yet the Hospital billed the Government for these tests and therapies, whether it was pre admission or post discharge under the diagnosis related group (DRG).

370. The Hospital set up a scheme to defraud the United States Government in that it regularly classified patients as outpatients because, if the care was rendered to an in patient, the care would not be reimbursed by Medicare, because

the care would fall within the above described 72 hour window. The charges would be included in the Diagnosis Related Group (DRG), not as a separate visit. If, on the other hand, a patient was brought in for a test as an outpatient, the claim could be submitted as a covered test under Medicare.

371. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Melrose-Wakefield Hospital knowingly filed improper claims in that it presented claims for medical items or service that it knew were not provided as claimed, and the defendant Hospital filed claims that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided. 42 U.S.C. §1320a-7a(a)(1)(A).

372. The Hospital regularly scheduled testing and lab work for patients while they were inpatients, but the testing and the lab work were scheduled to occur outside the 72 hour window after the patient was discharged. Pulmonary Stress tests and pulmonary function tests, for example, were prescribed to the in-patient, but performed as out-patient after discharge, after the 3 day window - the 72 hours - had passed.

373. The Hospital regularly submitted for payment non-physician outpatient services that were rendered within the diagnostic group payment window. Pulmonary Function Tests (PFT) stress

tests, arterial blood gas tests (ABC's), Laboratory tests, Psychiatric outpatient services and X-Rays all were prescribed within the 72 hours before admission and after discharge, yet scheduled outside the window in order to obtain Medicare reimbursement.

374. Patients brought in for pre op testing also were within the three day window and should not have been billed as outpatients, but they were.

375. Patients who went to the Oncology Clinic for testing and diagnosis, and then were admitted, should not have billed the U.S. Government, because the testing as an outpatient fell within the 72 hour window prior to admission.

376. Outpatients who bad stress tests, or arterial blood gas tests (ABC's) or pulmonary function tests (PF'T's), and then had to be admitted after the tests were performed, would fall within the 72 hour window and therefore the tests would have been covered under the DRG relating to their admission, but there was no order or prescription to indicate medical necessity and the Government should not have been billed for these tests. But it was.

377. Patients who were readmitted due to premature discharge also fell within the 72 hour window, but the Government was billed in this instance as well.

378. The Relator witnessed time and again after July 1994 that patients who went through cardiac

rehabilitation, pulmonary rehabilitation, or through the oncology clinic and cardiac stress testing on an outpatient basis, and then developed complications and had to be admitted, fell within the 3 day window, but yet claims were submitted for the outpatient visit, even though the patient fell within the 3 day window.

379. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

380. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme M

THE HOSPITAL FRAUDULEN'T'LY BILLED CROUP SESSIONS AS INDIVIDUAL SESSIONS.

381. Patients who were involved in a group therapy program in outpatient rehabilitation, in psychiatric and psychological rehabilitation, cardiac rehabilitation, occupational therapy, physical therapy, and pulmonary rehabilitation - all involving group sessions with several patients together for the one session - were billed as if an individual session were taking place.

382. The individual patients who were members of a group session going through cardiac and pulmonary rehab sessions were billed individually on separate bills for each individual member of that group.

383. For example, in a room with 20 psychiatric patients who were there for a group session, the Hospital billed the session as an individual psychiatric session with each of the 77 individual patients at that group session resulting in twenty bills for each patient to be reimbursed by Medicare and Medicaid.

384. The Hospital also billed sleep studies as being attended when the sleep studies were not attended.

385. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a-7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. Under 42 U.S.C. §1320a-7a(a)(1)(B), the defendants presented claims that were for medical or other items or services that the defendants knew, or should have known, were false or fraudulent.

386. Billing for outpatient rehabilitation was submitted as if it were individual sessions when in fact it was as group sessions. Under the HCFA Carriers Manual, Part 3, § 2150, professional clinical psychologists services are

not bundled.

387. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

388. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme N

THE HOSPITAL WAS INVOLVED IN KICKBACKS, SELF REFERRALS AND CONFLICTS OF IN'T'EREST

389. Hospitals and physicians must not improperly influence patients in their selection of a home health agency.

390. The arrangements of the Hospital with its physicians and with the home health agencies violated 42 U.S.C. 1320a-7b(b) and 59 Reg. 65372, in that they were arrangements that were established between those in a position to refer business, such as physicians, and those providing items or services for which a federal health care program pays. The defendant Hospital took away the free choice in the selection of a home

health agency by engaging in patient steering, patient channeling, and market leveraging and downstream referrals.

391. 42 CFR § 420.206 et seq requires disclosure of persons having ownership, financial, or control interest in any provider of services and care claiming Medicare or Medicaid reimbursement.

392. A disclosing entity must submit the name and address of each person with an ownership or control interest in the entity of in any subcontractor in which the entity has direct or indirect ownership interest totaling 5% or more. The defendants failed to do so.

393. The defendant Hospital told its practitioners to call home care starts to Lawrence Memorial Hospital's Home Care company. Lawrence Memorial Hospital is another hospital that comes under the ownership and control of the defendant Hallmark Health System, Inc. One purpose of this remuneration was to induce the Hospital to refer outpatients to Home Care Providers. The hospital based physician was referring patients to the home care unit and doing a plan of care.

394. The Medical Director of Medical Home Providers, a facility that provides equipment to patients at home, was Doctor Ronald Sen. The Medical Director for pulmonary rehabilitation at the Center for Optimum Care was Doctor Ronald Sen. The Medical Director of Respiratory Therapy at Melrose-Wakefield Hospital was

Doctor Sen. In addition to his present duties on the staff at the Hospital, he is presently a trustee at Melrose-Wakefield Hospital.

395. The Medical Home Provider company, of which Dr. Sen was the Medical Director, got home care referrals because of the incentive which was provided to the Hospital when the 02 Concentrator and the Bipap were provided by the Home Care company to the defendant Hospital for use.

396. The Hospital billed Medicare for the use of this equipment, and the equipment was left at the Hospital as part of the kickback scheme.

397. Mohammed Akbarian was Chief of Medicine, and he set up the directives and the policies for physicians as well as other employees of the defendant Melrose-Wakefield Hospital, directing them to refer patients to Normandy House. Doctor Akbarian owned Normandy House, and it was a self referral and a conflict of interest when employees of the defendant Hospital were directed to refer patients to this nursing home. The same thing was happening with Dr. Michael Zak, who was the Medical Director at American Home Care.

398. The Medical Director, Anthony Dichiara along with Karen Mahoney and Rochester Melody had ties to Medical Home Providers and were gathering data on patients that was intentionally falsified, then they referred these patients to Medical Home providers for Home Oxygen.

399. Personnel at Melrose-Wakefield Hospital took all supplies free of charge when ambulances brought patients to the Hospital Emergency Room.

400. The ambulance companies were allowed to restock their ambulances and take supplies from the Hospital, and the idea was just bring the patients to the hospital, and keep bringing more patients. The provision of free goods to an ambulance company constitutes prohibited remuneration.

401. The defendant Hospital took advantage of its control over patient access and extracted "kickbacks" from hospital-based physicians. The Hospital , without charge restocked the ambulance with supplies and medications after the ambulance transported patients to the Hospital. This activity was conducted to get the ambulance to bring patients to Melrose-Wakefield, rather than to a competing hospital. The Hospital billed Medicare for these provisions of free supplies.and medications, and this practice fits squarely within the meaning of remuneration for purposes of the anti-kickback statute.

402. Harold Pini was the sales representative for Medical Home Providers. Beginning in August, 1994, he provided a Bipap Unit and an oxygen concentrator to be used by the hospital in areas that did not have piped on 02. He also every month would drop off B ipap nasal masks. He did this so that the Home Care providers would get

the hospital to refer patients and out patients to them.-He was leaving the 02 concentrators and the Bipap systems at the hospital in a kick back and reimbursement schdme to gain referrals.

403. The equipment left in the hospital by Medical Home Providers was billed by the Hospital to Medicare for use of the equipment. This billing was unallowable and a Stark 2 selfreferral.

404. These acts constituted gain sharing with hospital based physicians. The bonuses were kickbacks. Respiratory therapists at Malden, another of the defendant Hallmark's hospitals, were acquiring information on patients and then doing the home visits on those patients. To this day the Respiratory Therapists are collecting data on patients to justify the need for oxygen, then calling the start into the Home Care company that has the referring.

405. The Hospital discharge planning evaluation did not include an evaluation of the patient's likely need for appropriate post-hospital services. The patients were not provided information which listed the Medicare certified Home Health agencies in the area requested to be included on the list.

406. Melrose-Wakefield Hospital did not provide the patient with information regarding the extent of its financial interest, or the financial interest of its Medical Director of the Respiratory Unit, in the Home Health Care agency and the financial interest that its physicians had in the Home

Health Care agency or nursing home.

407. The Medical Equipment Companies (DME's) were loaning out their equipment and doing this to gain referrals. This was a conflict of interest and in violation of the anti kick back statutes.

408. The home care equipment that was supplied by these companies was billed for even though the patient was in the hospital or had expired. This applies to all patients that Olincare and Medical Home Providers provided services to.

409. Ambulances from AMR, Action, Cataldo and Lifeline would remove respiratory therapy supplies such as 02 masks and Ambus. This was not billed to or from the ambulance companies, and was clone as an incentive to bring patients to Melrose-Wakefield, but showed up on cost reports billed to HCFA under hospital costs.

410. Rules and regulations were violated for financial arrangements with physicians. Ownership of Courtyard Nursing Home violated the Stark II self referral rule when patients were referred to that nursing home, in that it involved a joint venture. The same applied to the Normandy House that was owned by Mohammed Akbarian, M.D.

411. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial gums of money to the defendants to which these defendants were not entitled.

412. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every, fraudulent act.

Scheme O

PULMONARY REHABILITATION WAS FRAUDULENTLY BILLED AS PHYSICAL THERAPY REHABILITATION

413. 42 CFR § 410.59 et seq. sets the standards for Medicare and Medicaid reimbursement for various-therapy services; and Medicare Part B, for example, pays for occupational therapy services if they are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine; and they (the physical therapy or occupational therapy) services are furnished under a written plan of treatment that meets the requirements of 410.61.

414. Medicare and Medicaid does not approve reimbursement for Respiratory Therapy and Pulmonary Rehabilitation services, and bills under both categories are routinely denied by the Government for Medicare and Medicaid reimbursement.

415. So Melrose-Wakefield Hospital changed the code of the care. The defendant Hospital instituted a fraudulent scheme to obtain Medicare and Medicaid reimbursement by labeling all Respiratory Therapy and Pulmonary Rehabilitation services provided by the defendant Hospital as Physical Therapy. Again, this was done because Medicare/Medicaid Would and did approve reimbursement for Physical Therapy.

416. Medicare requires accurate reporting of financial information on cost reports and credit balances. 42 C.F.R. § 413.20. And under 42 U.S.C. §1320a7a(a)(1)(A) the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed. Under 42 U.S.C. §1320a-7a(a)(1)(A) the defendant Hospital filed claims that were based on codes that the defendant knew would result in greater payments than what an appropriate code would have provided. The defendants presented claims that were for medical or other items or services that the defendants knew, or should have known, were false or fraudulent under 42 U.S.C. §1320a-7a(a)(1)(B).

417. The Hospital engaged in the practice, in order to obtain Medicare reimbursement for Pulmonary Rehabilitation and Respiratory Therapy, of classifying and coding Pulmonary Rehabilitation as Physical Therapy.

418. For example, a pulmonary stress test fell within the category of Respiratory Therapy, but Medicare wouldn't pay for Respiratory Therapy, so the defendant Hospital changed the category from Pulmonary Rehab to Physical Therapy, and Medicare paid.

419. The department of Respiratory Therapy performed 250 stress tests over a three year period, and these tests belonged in the category of Respiratory Therapy. The tests were submitted to Medicare/Medicaid as Physical Therapy. A pulmonary stress test cost in the range of $1500 per test, and the Hospital got Medicare to pay for the test after the coding was changed from Pulmonary Rehab to Physical Therapy. The Hospital also billed for V02 and Vco2 and got Medicare to pay for it.

420. And if the patient was booked for a pulmonary stress test as an in patient, and therefore fell within the 72 hour window described herein in Scheme L, the patient would be discharged and given the pulmonary stress test for an outpatient, to obtain reimbursement from Medicare.

421. Accordingly, the United States of America and the Medicare and Medicaid Programs paid substantial sums of money to the defendants to which these defendants were not entitled.

422. Pursuant to the civil penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for

creating and submitting these false and fictitious records is well in excess of ten million dollars at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

Scheme P

ADDITIONAI SCHEMES

423. Each of the below listed schemes involves a violation of the Medicare and Medicaid requirement for accurate reporting of financial information on cost reports and credit balances under 42 C.F.R. § 413.20.

424. In the schemes below described, the defendants knowingly filed improper claims in that they presented claims for medical items or service that they knew were not provided as claimed in violation of 42 U.S.C. §1320a-7a(a)(1)(A). The defendant Hospital filed claims that were based on codes that the defendants knew would result in greater payments than what an appropriate code.would have provided in violation 42 U.S.C. §1320a-7a(a)(1)(A)

425. The defendants presented claims that were for items or services that the defendants knew were not medically necessary in violation 42 U.S.C. §1320a-7a(a)(1)(E). The defendants presented claims that were for medical or other items or services that the defendants knew, or should have known, were false or fraudulent in violation 42 U.S.C. § 1320a-7a(a)(1)(B).

426. The hospital submitted claims for oxygen when the patient didn't use it. In other words, the Hospital didn't adjust the rates when the patient wasn't able to use the equipment during his or her hospitalization.

427. Patients were charged for Oxygen and suction when all that Medicare allowed was a charge for the initial set up of the Oxygen. But every day that the patient was hospitalized, a recurrent charge went in. Under 42 CFR § 411.4 Medicare does not pay for a service if the beneficiary has no legal obligation to pay for the service. And under 42 CFR § 410.12, the services must be certified as being medically necessary. Sections 1814(a)(2) and 1835(a)(2) of the Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services.

428. The Hospital billed for Chest Physical Therapy that was not performed, and under 42 CFR § 411.4 Medicare does not pay for a service if the beneficiary has no legal obligation to pay for the service.

429. Pulse Oximetery was used as a vital sign and was billed but never ordered by physicians. Billing for Oximetry spot checks at $75 a check was not allowable as an expense. It was being used as a vital sign. Nursing requested 02 saturation on patients as a vital sign, and if there was no order, there should have been no submission of a bill or claim, but there was.

Under 42 CFR § 410.12, if the services are subject to physician requirements, they must be certified as being medically necessary.

430. The Relator John C. Karvelas, as a Respiratory Therapist, would give the patient, when he or she was on vents, two puffs of a metered dose inhaler. The Medicare charge for the metered dose inhaler was generated in the pharmacy. A hand held nebulizer was used by Respiratory Therapists to give treatment to a patient called an updraft. The billing to Medicare for an updraft with the hand held nebulizer came under a separate and different category than the metered dose inhaler. The Respiratory Therapists gave the patients puff inhalers, which charge was generated and billed through the pharmacy, and this care was billed as a new, additional charge, as if the patient were being treated with a hand held nebulizer.

431. The defendant Hospital altered charts and removed charts, after the patients were discharged and after they were dead. Under 42 CFR § 411.4, Medicare does not pay for a service if the beneficiary has no legal obligation to pay for the service.

432. Under 42 CFR § 410.38 Medicare Part B pays for the rental or purchase of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs. Another example of durable equipment is equipment that is reusable, such as crutches, canes, walkers, wheel chairs, and traction.

433. Medicare does not pay for medical equipment or supplies which are not reusable, that are not durable, such as IV solutions, medications, catheters, colostomy bags, drainage equipment, trays or tubing, ventilators, IPPB Nebulizers, CPAP, and Air Flotation Beds. But Melrose-Wakefield Hospital submitted claims for non reusible medical equipment and supplies, and these claims were paid by the Government.

434. Cummings Rehab at the defendant Hospital claimed ancillary medical supplies such as dietary, administrative and general costs, as well as consultant fees, computers and software and infectious waste removal services.

435. Patients were also charged, and Medicare was billed, for Oxygen, hand feeding, incontinency care, tray service, enemas, tongue depressors, paper, mouthwash, aspirin, water pitcher basins, alcohol preps, cotton balls, band aid, antacid, and these were not reusable supplies to be used for daily living.

436. The Hospital billed. Medicare for evaluation on the initiation of therapy, and this was not an allowable cost. It was the same as a nursing assessment.

437. In August, 1996, 17 boxes of Albuterol at 25 vials per box were donated by a Dorsey Henderson patient to the department. Tony Dichiara used the medications and billed for the medications. A claim was made to Medicare, and 425 treatments were billed. Under 42 CFR § 411.4, Medicare

does not pay for a service if the beneficiary has no legal obligation to pay for the service. None of the beneficiaries of the service had a legal obligation to pay for the medications, yet Medicare was billed for these services.

438. The Hospital cost reports claimed unallowable costs such as general and administrative costs, planning and marketing, air fare, food, gifts, entertainment, alcohol and fringe benefits bonuses, dues and donations. The Hospital cost reports included taking physicians and their wives out for dinner and listing these items as administrative costs, along with alcohol and entertainment, none of which is a Medicare reimbursable item. The Hospital claimed administrative costs like entertainment, Boston Red Sox tickets and Bruins and Celtics tickets as well as membership to MHA and AHA for lobbying.

439. Under 42 CFR § 410.12, if the services are subject to physician requirements, they must be certified as being medically necessary. These cost reports carried no certification of medical necessity, nor were they legitimately covered as general administrative costs.

440. Patients that were admitted to the Hospital continued to be charged at the full rate by the Home Care Companies, and the rate wasn't adjusted when the patient wasn't able to use the equipment due to the hospitalization.

441. A hospital employee was getting paid a premium of $22 an hour by the Hospital for the same job the Relator was performing while she also was on the clock as a per diem employee. She would score sleep studies and bill Medicare $70 per patient. She, with the approval of the defendant Melrose-Wakefield Hospital, was double dipping.

442. Patients were in the hospital while nursing aides made visits to the patient's residence. Although the patient was not there, the nurses' aides claimed that they were, and they billed Medicare for the visit.

443. The Relator, when he was employed at the defendant Optimum Health care, was urged to put in for mileage in going from Optimum to Wingate to Optimum. He put in for mileage, was never reimbursed, yet Optimum Care was reimbursed by the Govenment.

444. Emerson chest tubes were billed as suction.

445. Ambulance service is covered only if it is to an appropriate local destination and if the service meets the medical necessity requirements. One requirement is that the beneficiary's medical condition "is such that other means of transportation would be contraindicated." 42 CFR § 410.40

446. The Relator John C. Karvelas in the Respiratory Therapy Department transported patients in house by wheel chair, yet the ambulance company would write down that the patient was

bed ridden. Ambulance service was billed when it was not medically necessary, in that the patient could have been transferred by the use of a wheel chair.

447. Evaluations were billed for after death or discharge, and treatments were not documented. There also was a serious question on how many patients even fit the criteria for services or therapy, in that the services were not documented or prescribed by a physician in the patient's chart.

448. Pursuant to the civil, penalty provisions of the False Claims Act, the sum for which Defendants are liable to the United States of America for creating and submitting these false and fictitious records is well in excess of ten million dollars, at an amount to be determined when the fines and penalties are assessed against each and every fraudulent act.

CLAIMS

FIRST CAUSE OF ACTION
False Claims Act: Presentation of False Claims
(31 U.S.C. § 3729(a)(1))

449. Plaintiffs the United States and Relator repeat and reallege each allegation in paragraphs 1 through 448 as if fully set forth herein.

450. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

451. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

SECOND CAUSE OF ACTION
False Claims Act: Presentation of False Claims
(31 U.S.C. § 3729(a)(2))

452. Plaintiffs the United States and Relator repeat and reallege each allegation in paragraphs 1 through 451 as if fully set forth herein.

453. Defendants knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims for payment or approval to the United States.

454. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

THIRD CAUSE OF ACTION
False Claims Act: Presentation of False Claims
(31 U.S.C. § 3729(a)(7))

455. Plaintiffs the United States and Relator repeat and reallege each allegation in paragraphs 1 through 454 as if fully set forth herein.

456. Defendants knowingly made, used, or caused to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

457. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

FOURTH CAUSE OF ACTION
False Claims Act: Retaliation, Wrongful Termination
(31 U.S.C. § 3730(h))

458. The allegations in the preceding paragraphs are realleged as if fully set forth below.

459. Throughout John Karvelas' employment at Melrose-Wakefield, he complained to management about deficiencies in the care and about the activites hereinbefore related within his department and throughout the Hospital.

460. During his employment as a Respiratory Therapist, the Relator refused to participate in the cover up of the neglect, the understaffing, the defective ABG testing apparatus, and the cover up of the very serious threat to the patients' health.

461. Defendant Melrose-Wakefield discharged John Karvelas in retaliation for his investigation of

the defendants' violations of its Government contracts under Medicaid and Medicare and its False Claims Act violations.

462. Relator John Karvelas was discriminated against in his termination by Defendant Melrose Wakefield Hospital by and through its officers, agents, and employees, because of lawful acts done by him in the furtherance of an action under the False Claims Act, including his participation in the investigation of an action under the False Claims Act and his reporting to the United States Government the fraudulent actions of the defendants.

463. Defendants actions set forth above violated 31 U.S.C. § 3730(h)) and damaged John Karvelas in an amount to be determined at trial.

FIFTH CAUSE OF ACTION
R.I.C.O. Racketeering under Federal Law

464. The allegations of paragraphs 1 through 463 are re-alleged as if fully set forth below.

465. Defendants were at all times relevant hereto, operating as enterprises engaged in or affecting interstate or foreign commerce within the meaning of 18 U.S.C. §1962.

466. In an effort to defraud the United States of America, the defendants by telephone and through the United States Mail, and in contact with vendors, contractors, subcontractors and agents, servants and or employees of the said

defendants and agents, servants, and or employees of the United States Government, made numerous false and fraudulent statements to representatives of the U.S. Government concerning costs, claims, submissions, and pricing data.

467. Said conduct constitutes a violation of 18 U.S.C §§1341,1343, and 1347. The conduct violates as well 18 U.S.C. § 1035 relating to false statements relating to health care matters. 468. The aforementioned acts of mail fraud and wire fraud have occurred within ten years of each other and constitute a pattern of racketeering activity within the meaning of 18 U.S.C. §§1961(a) and 1961(5) and, therefore, also constitute a violation of 18 U.S.C. §1962.

WHEREFORE, as to the FIRST, SECOND AND THIRD CAUSES OF ACTION, RELATOR JOHN C. KARVELAS, on behalf of himself and the United States of America prays:

(a) That this Court enter judgment against defendants in an amount equal to three times the amount of damages the United States Government has sustained because of defendants' actions, plus a civil penalty of $5,000 - $10,000 for each action in violation of 31 U.S.C. §3729, and the cost of this action, with interest, including the cost to the United States Government for its expenses related to this action;

(b) That the Relator be awarded all costs incurred, including reasonable attorneys' fees;

(c) That in the event that the United States of America proceeds with this action, the Relator be awarded an amount for bringing this action of at least 15% but not more than 25% of the proceeds of the action or settlement of the claim;

(d) That in the event that the United States of America does not proceed with this action, that the Relator be awarded an amount for bringing this action that the Court decides is reasonable for collecting the civil penalty and damages, which shall be not less than 25% and not more than 30% of the damages or settlement proceeds recovered by the United States of America;

(e) That the Relator be awarded prejudgment interest;

(f) That a trial by jury be held on all issues;

(g) That the United States of America and Relator John C. Karvelas receive all other relief, both at law or equity, to which they reasonably may be entitled.

WHEREFORE, as to the FOURTH CAUSE OF ACTION, RELATOR JOHN C. KARVELAS, on his own behalf, prays:

(a) That he be awarded all relief necessary to make him. whole, including, but not limited to, two times his back pay, interest on the back pay, and.

compensation for all special damages sustained, including attorneys fees and costs;

(b) compensatory and punitive damages, including personal injury damages for pain and suffering and loss of reputation, to which he is entitled pursuant to 31 U.S.C. § 3730(h);

(c) Such other relief as the Court finds appropriate.

WHEREFORE, as to the FIFTH CAUSE OF ACTION, RELATOR JOHN C. KARVELAS on behalf of the United States of America and of himself prays:

That said damages awarded to the United States of America be trebled in accordance with 18 U.S.C. § 1964(c).

RELATOR JOHN C. KARVELAS

By_____

JOHN F. MURPHY
1324 Asylum Avenue
Hartford Connecticut 06105-6011
Fed. Bar No. ct00056
Tel. No. (860) 233-9946
Fax. No. (860) 523-5065

RELATOR DEMANDS A TRIAL BY JURY.

_____

John F. Murphy

RELEVANT DOCKET ENTRIES

District Court of Massachusetts:

04-27-01	Complaint Filed
04-27-01	Order Sealing File
05-07-02	Order Unsealing File
07-15-02	Defendant's Motion to Dismiss Plaintiff's Complaint filed
09-09-02	Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss filed
05-21-03	Memorandum and Order
06-12-03	Notice of Appeal

U.S. Court of Appeals for First Circuit:

06-30-03	Notice filed by Appellant John C. Karvelas
06-30-03	Record filed
07-14-03	Docketing Statement filed by John C. Karvelas
08-26-03	Brief filed by Appellant John C. Karvelas
09-25-03	Brief filed by Appellees
10-10-03	Reply Brief filed by Appellant

11-03-03	Case argued
02-23-04	Judgment entered
02-23-04	Opinion
03-08-04	Petition for panel rehearing and rehearing en banc
03-25-04	Order denying petition for rehearing and rehearing en banc
04-05-04	Mandate issued

31 U.S.C. § 3729. False claims

(a) Liability for Certain Acts. — Any person who —

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(b) Knowing and Knowingly Defined. — For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information —

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information,

no proof of specific intent to defraud is required.

Rule 9. Pleading Special Matters

(b) Fraud, Mistake, Condition of the Mind. In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

SENATE REPORT NO. 99-345

[5266]

FALSE CLAIMS AMENDMENTS ACT OF 1986

P.L. 99-562, see page 100 Star. 3153

DATES OF CONSIDERATION AND PASSAGE

Senate August 11, October 3, 1986

House September 9, October 7, 1986

Senate Report (Judiciary Committee) No. 99-345, July 28, 1986 [To accompany S. 1562]

House Report (Judiciary Committee) No. 99-660, June 26, 1986 [To accompany H.R. 4827]

Cong. Record Vol. 132 (1986)

The Senate bill was passed in lieu of the House bill. The Senate Report is set out below.

SENATE REPORT NO. 99-345

[page 1]

The Committee on the Judiciary, to which was referred the bill (S. 1562) to amend the False Claims Act, and title 18 of the United States Code regarding penalties for false claims, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and

recommends that the bill, as amended, do pass.

* * * * * *

I. PURPOSE OF THE HILL

The purpose of S. 1562, the False Claims Reform Act, is to enhance the Government's ability to recover losses sustained as a result of fraud against the Government. While it may be difficult to estimate the exact magnitude of fraud in Federal programs and

[page 2]

procurement, the recent proliferation of cases among some of the largest Government contractors indicates that the problem is severe. This growing pervasiveness of fraud necessitates modernization of the Government's primary litigative tool for combatting fraud; the False Claims Act (31 U.S.C. 3729, 3730). The main portions of the act have not been amended in any substantial respect since signed into law in 1863. In order to make the statute a more useful tool against fraud in modern times, the Committee believes the statute should be amended in several significant respects.

The proposed legislation seeks not only to provide the Government's law enforcers with more effective tools, but to encourage (52671 any individual knowing of Government fraud to bring that information forward. In the face of sophisticated and widespread fraud, the Committee believes only a coordinated effort of both the Government and the citizenry will decrease this wave of defrauding public funds. S. 1562 increases

incentives financial and otherwise, for private individuals to bring suits on behalf of the Government. The False Claims Reform Act also modernizes jurisdiction and venue provisions, increases recoverable damages, raises civil forfeiture and criminal penalties, defines the mental element required for a successful prosecution and clarifies the burden of proof in civil false claims actions.

II. BACKGROUND STATEMENT

A. NEED FOR LEGISLATION

Evidence of fraud in Government programs and procurement is on a steady rise. In 1984, the Department of Defense conducted 2,311 fraud investigations, up 30 percent from 1982. Similarly, the Department of Health and Human Services has nearly tripled the number of entitlement program fraud cases referred for prosecution over the past 3 years.

Detected fraud is, of course, an imprecise measure of how much actual fraud exists. The General Accounting Office in a 1981 study found that "most fraud goes undetected."[1] Of the fraud that is detected, the study states, the Government prosecutes and recovers its money in only a small percentage of cases.

SENATE REPORT NO. 99-345
APPX. 2

Fraud permeates generally all Government programs ranging from welfare and food stamps benefits, to multibillion dollar defense procurements, to crop subsidies and disaster relief programs.[2] While fraud is

obviously not limited to one Government agency, defense procurement fraud has received heightened attention over the past few years. In 1985, the Department of Defense Inspector General, Joseph Sherick, testified that 45 of the 100 largest defense contractors, including 9 of the top 10, were under investigation for multiple fraud offenses.[3] Additionally, the Justice Department has reported that in the last year, four of the largest defense contractors, General Electric, GTE, Rockwell and Gould,

[page 3]

have been convicted of criminal offenses while another, General Dynamics, has been indicted and awaits trial.[4]

No one knows, of course, exactly how much public money is lost to fraud. Estimates from those who have studied the issue, including the, General Accounting Office, Department of Justice, and Inspectors General, range from hundreds of millions of dollars to more than $50 billion per year.

[5268] The 1981 GAO report on fraud estimated that loss to the Government from 77,000 reported cases over 2 ½ years would total between $150 and $210 million. But the report went on to note:

These losses are only what is attributable to known fraud and other illegal activities investigated by the Federal agencies in this study. It does not include, of course, the cost of undetected fraud which is probably much higher because weak internal controls allow fraud to flourish.[5]

The Department of Justice has estimated fraud as draining 1 to 10 percent of the entire Federal budget.[6] Taking into account the spending level in 1985 of nearly $1 trillion, fraud against the Govemment could be costing taxpayers anywhere from $10 to $100 billion annually.

In the Defense Department procurement budget alone, we may be losing anywhere from $1 to $10 billion if the Justice Department estimate is accurate.

Defense Department Inspector General Joseph Sherick estimated that DOD loses more than $I billion just from fraudulent billing practices. [7]

The cost of fraud cannot always be measured in dollars and cents, however. GAO pointed out in its 1981 report that fraud erodes public confidence in the Government's ability to efficiently and effectively manage its programs.[8] Even in the cases where there is no dollar loss-for example where a defense contractor certifies an untested part for quality yet there are no apparent defects -the integrity of quality requirements in procurement programs is seriously undermined. A more dangerous scenerio exists where in the above example the part is defective and causes not only a serious threat to human life, but also to national security.

Fraud is perhaps so pervasive and, therefore, costly to the Government due to a lack of deterrence. GAO concluded in its 1981 study that most fraud goes undetected due to the failure of Governmental agencies to effectively ensure accountability on the part of program recipients and Government contractors. The

study states:

For those who are caught committing fraud, the chances of being prosecuted and eventually going to jail are slim . . . The sad truth is that crime against the Government often does pay.[9]

[page 4]

[5269]Many changes have been made since 1981 which have brought about some encouraging improvements in the Government's efforts against fraud. With the inception of Inspectors General, an increased number of fraud allegations are being addressed. However, available Department of Justice records show most fraud referrals remain unprosecuted and lost public funds, therefore, remain uncollected.[10]

In 1984, the Economic Crime Council of the Department of Justice targeted two major Federal programs-defense procurement and health care benefits-as economic crime areas in which stronger enforcement and deterrence were needed. In the Council's April, 1985 report to the Attorney General, it concluded that while some progress had been made, the level of enforcement in defense procurement fraud remains inadequate.[11]

Through hearings and research on Government fraud, the Committee has sought and is continuing to seek out the reasons why fraud in Government programs is so pervasive yet seldom detected and rarely prosecuted. It appears there are serious roadblocks to obtaining information as well as weaknesses in both investigative and litigative tools. In an effort to correct some of those

weaknesses, the Committee has reviewed the Government's remedies against false claims and developed the legislative improvements embodied in S. 1562.

The False Claims Act currently permits the United States to recover double damages plus $2,000 for each false or fraudulent claim. Enacted in 1863 in response to cases of contractor fraud perpetrated on the Union Army during the Civil War, this statute has been used more than any other in defending the Federal treasury against unscrupulous contractors and grantees. Although the Government may also pursue common law contract remedies, the False Claims Act is a much more powerful tool in deterring fraud.

Since the act was last amended in 1943, several restrictive court interpretations of the act have emerged which tend to thwart the effectiveness of the statute. The Committee's amendments contained in S. 1562 are aimed at correcting restrictive interpretations of the act's liability standard, burden of proof, qui tam jurisdiction and other provisions in order to make the False Claims Act a more effective weapon against Government fraud.

Detecting fraud is usually very difficult without the cooperation of individuals who are either close observers or otherwise involved in the fraudulent activity. Yet in the area of Government fraud, there appears to be a great unwillingness to expose illegalities.

In 1983, the U.S. Merit Systems Protection Board conducted a survey of approximately 5,000 Federal

Government employees to determine to what extent observed fraud, waste, and abuse was going unreported. The Merit Systems Board reported that 69 percent of those who believed they had direct knowledge of illegalities failed to report the information. Those employees who chose not to report fraud were then asked why they failed to come forward. The

[page 5]

[5270] most frequently cited reason given (53 percent) was the belief that nothing would be done to correct the activity even if reported. Fear of reprisal was the second most cited reason (37 percent) for nonreporting.[12]

In hearings before the Subcommittee on Administrative Practice and Procedure, individuals who had "blown the whistle" on their Government contractor employers offered several reasons for what one termed the "conspiracy of silence" among contractor employees.[13]

Robert Wityczak, a triple-amputee veteran who exposed mischarging practices at Rockwell International, said his "ethical principles" were tested to the limit when faced with the difficult choice of either keeping quiet about mischarging be witnessed or risking the loss of his job.

I agonized over my decision to step forward. I have a wife, five children and a house mortgage * * * Yet once I made the decision to tell the truth about what was going on, I found no one inside or outside the company

willing to act on the information.[14]

Wityczak said his initial efforts to report the mischarging started what was to result in a long-term harassment campaign by his superiors which finally resulted in Wityczak being discharged. Wityczak said:

I told my supervisors * * * I would no longer mischarge on my time cards. They reacted angrily, calling me anti-management, anti-Rockwell, and a pain in the ass * * * Gradually, I was squeezed out of the work I was doingI was stripped of my confidential security, my access to documents was limited, I was excluded from meetings and was put to work doing menial tasks outside my job description, such as sweeping, making coffee and cleaning a 50 gallon coffee pot.[15]

Wityczak said he has concluded not only from his own experience but from talking to his fellow workers that there is "absolutely no encouragement or incentive" for individuals working in the defense industry to report fraud. Instead, he said, there is a great disincentive due to employer harassment and retaliation. "Contractor employees are generally all for exposing fraud, but most individuals just simply cannot and will not put their head on the chopping block," Wityczak said. [16]

Wityczak's comments were echoed by Mr. John Gravitt, another witness who testified in regard to time card mischarging at a General Electric plant in Ohio. Gravitt agreed that most individuals working in defense contractor plants are afraid to expose fraud. Gravitt also pointed out that without cooperating employees, Gov-

[5271] emment auditors would rarely detect abuses. Gravitt explained that notice of an impending audit normally travels through the contractor plant "like wildfire" and "everybody straightens up their act." Wityczak said his experience with Government audits was similar in that all departments were put on "red alert" when auditors came through.[17]

The Committee believes changes are necessary to halt the so-called "conspiracy of silence" that has allowed fraud against the Government to flourish. John Phillips, co-director of the Center for Law in the Public Interest, a nonprofit law firm specializing in assisting "whistleblowers", testified that more effective fraud detection will only occur if changes are made at the basic employee level. Phillips said people who are unwilling participants in fraudulent activity must be given an opportunity to speak up and take action without fear and with some assurance their disclosures will lead to results.[18]

Hearing testimony also suggested that the collection of information which leads to successful fraud recoveries is hampered by the Government's inadequate investigative tools. Justice Department witnesses stated that as in all complex white-collar fraud matters, investigative tools are critical to successful prosecutions. Mr. Jay Stephens, Associate Deputy Attorney General, testified that in civil false claims cases the Department's civil attorneys rely in large part on FBI reports and information gathered by the various Inspectors Gencral,[19] but that civil investigative capacity is often hampered, however, in two ways.

First, the civil attorneys themselves have no authority to compel production of documents or depositions prior to filing suit. Currently, some cases are weeded out and not filed because information is missing-information that might have turned up through pre-suit investigation if the tools were available.[20]

Second, information is often incomplete due to the existence of a prior grand jury investigation resulting in evidence protected by Rule 6(e) of the Federal Rules of Criminal Procedure. On June 30, 1983, the Supreme Court ruled in United States v. Sells Engineering, Inc., 103 S. Ct. 3133[21] (1983), that Department of Justice attorneys handling civil cases are not "attorneys for the government" for the purposes of Rule 6(e) of the Federal Rules of Criminal Procedure. Therefore, they may not obtain grand jury materials that pertain to their cases without a court order; and such an order may be granted only upon a showing of "particularized need." The court further held that the "particularized need" standard was not satisfied by a showing that nondisclosure would cause lengthy delays in litigation or would require substantial duplication of an investigation already conducted by the Government using scarce investigative and audit resources.

Compounding the investigative problems are also various litigative hurdles. As a civil remedy designed to make the Government whole for fraud losses, the civil False Claims Act currently pro-

[page 7]

[5272] vides that the Government need only prove that the defendant knowingly submitted a false claim.

However, this standard has been construed by some courts to require that the Government prove the defendant had actual knowledge of fraud, and even to establish that the defendant had specific intent to submit the false claim,[22] for example, United States v. Aerodex, Inc., 469 F.2d 1003 (5th Cir. 1972). The Committee believes this standard is inappropriate in a civil remedy and presently prohibits the filing of many civil actions to recover taxpayer funds lost to fraud.

The Committee's interest is not only to adopt a more uniform standard, but a more appropriate standard for remedial actions. Currently, in judicial districts observing an "actual knowledge" standard, the Government is unable to hold responsible those corporate officers who insulate themselves from knowledge of false claims submitted by lower-level subordinates. This "ostrich-like" conduct which can occur in large corporations poses insurmountable difficulties for civil false claims recoveries.

The Committee is firm in its intention that the act not punish honest mistakes or incorrect claims submitted through mere negligence. But the Committee does believe the civil False Claims Act should recognize that those doing business with the Government have an obligation to make a limited inquiry to ensure the claims they submit are accurate.

The burden of proof in civil false claims cases has also evolved through caselaw into an ambiguous standard. Some courts have required that the United States prove a violation by clear and convincing, or even clear, unequivocal and convincing evidence, United States v. Ueber, 299 F.2d 310 (6th Cir. 1962), which the Justice

Department has testified is the "functional equivalent of a criminal standard."[23]

In addition to detection, investigative and litigative problems which permit fraud to go unaddressed, perhaps the most serious problem plaguing effective enforcement is a lack of resources on the part of Federal enforcement agencies.

Unlike most other types of crimes or abuses, fraud against the Federal Government can be policed by only one body-the Federal Government. State and local law enforcement are normally without jurisdiction where Federal funds are involved.

Taking into consideration the vast amounts of Federal dollars devoted to various complex and highly regulated assistance and procurement programs, Federal auditors, investigators, and attorneys are forced to make "screening" decisions based on resource factors.[24] Allegations that perhaps could develop into very significant cases are often left unaddressed at the outset due to a judgment that devoting scarce resources to a questionable case may not be efficient. And with current budgetary constraints, it is unlikely that the Government's corps of individuals assigned to anti-fraud enforcement will substantially increase.

[page 8]

[5273] An additional problem noted by hearing witnesses, exists when large, profitable corporations are the subject of a fraud investigation and able to devote many times the manpower and resources available to the Government. This resource mismatch

was recognized by DOD Inspector General Joseph Sherick who said that in far too many instances the Government's enforcement team is overmatched by the legal teams major contractors retain.[25]

The Committee believes that the amendments in S. 1562 which allow and encourage assistance from the private citizenry can make a significant impact on bolstering the Government's fraud enforcement effort. The idea of private citizen aid in false claims actions is, of course, not a new one, but dates back to the original enactment of the False Claims Act in 1863. Additionally, in other areas of enforcement such as antitrust and securities violations, the number of private enforcement actions far exceeds those brought by the Governmenl.[26]

B. HISTORY OF THE FALSE CLAIMS ACT AND COURT INTERPRETATIONS

The False Claims Act was adopted in 1863 and signed into law by President Abraham Lincoln in order to combat rampant fraud in Civil War defense contracts. Originally the act provided for both civil and criminal penalties assessed against one who was found to knowingly have submitted a false claim to the Government The civil penalty provided for payment of double the amount of damages suffered by the United States as a result of the false claim, plus a $2,000 forfeiture for each claim submitted.

In its present form, the False Claims Act empowers the United States to recover double damages from those who make, or cause to be made, false claims for money or property upon the United States, or who submit

false information in support of claims. In addition the United States may recover one $2,000 forfeiture for each false claim submitted in support of a claim. The imposition of this forfeiture is automatic and mandatory for each claim which is found to be false. The United States is entitled to recover such forfeitures solely upon proof that false claims were made, without proof of any damages. Fleming v. United States, 336 F2d 475, 480 (10th Cit. 1964), cert. denied, 380 U.S. 907 (1965). A forfeiture may be recovered from one who submits a false claim though no payments were made on the claim. United States v. American Precision Products Corp., 115 F. Supp. 823 (D. N.J. 1953). The False Claims Act reaches all parties who may submit false claims. The term "person" is used in its broad sense to include partnerships, associations, and corporations-United States v. Hanger One, Inc., 563 F2d 1155, 1158 (5th Cit. 1977); United States v. National Wholesalers, Inc, 236 F.2d 944 (9th Cir. 1956)-as well as States and political subdivisions thereof. Cf. Ohio v. Helvering, 292 U.S. 360, 370 (1934); Georgia v. Evans, 316 U.S. 153, 161 (1942); Monell v. Department of Social Services of the City of New York, 436 U.S. 658[27] (1978).

[page 9]

[5274] The False Claims Act is intended to reach all fraudulent attempts to cause the Government to pay out sums of money or to deliver property or services. Accordingly, a false claim may take many forms, the most common being a claim for goods or services not provided, or provided in violation of contract terms, specification, statute, or regulation. For example, United States v. Bornstein, 423 U.S. 30328 (1976); United States v. National Wholesalers, 236 F.2d 944

(9th Cit. 1956), cert. denied, 353 U.S. 930 (1957); Henry v. United States, 424 F.2d 677 (5th Cit. 1970). A false claim for reimbursement under the Medicare, Medicaid or similar program is actionable under the act, Peterson v. Weinberger, supra, as is a false application for a loan from a Government agency, United States v. Neifert-White Co., 390 U.S. 228 (1968), or a false claim in connection with a sale financed by the Agency for International Development or Export-Import Bank, United States v. Chew, 546 F2d 309 (9th Cit. 1978), and such claims may be false even though the services are provided as claimed if, for example, the claimant is ineligible to participate in the program, or though payments on the Government loan are current, if by means of false statements the Government was induced to lend an inflated amount. A false claim may take other forms, such as fraudulently cashing a Government check, which was wrongfully or mistakenly obtained. United States v. Veneziale, 268 F.2d 504 (3rd Cir. 1956). A fraudulent attempt to pay the Government less than is owed in connection with any goods, services, concession, or other benefits provided by the Government is also a false claim under the act. See Smith v. United States, 287 F.2d 299 (5th Cir. 1961); United States v. Garder, 73 F. Supp. 644 (N.D. Ala. 1947). For example, the Committee considers a false application for reduced postal rates to be a false claim for postal services, and agrees with the wellreasoned decision in United States ex rel. Rodriguez v. Weekly Publications, Inc., 68 F. Supp. 767, 770 (S.D. N.Y. 1946), that whether such benefits are received by means of a reduction in the amount paid by the Government or by means of subsequent claims for reimbursement is a matter of bookkeeping rather than of substance, and therefore, rejects the contrary result reached in United

States v. Marple Community Record, Inc., 335 F. Supp. 95 (E.D. Pa. 1971); see also, United States v. Howell, 318 F.2d 162 (9th Cir. 1963).

Each separate bill, voucher or other "false payment demand" constitutes a separate claim for which a forfeiture shall be imposed, see, for example, United States v. Bornstein, 423 U.S. 303[29] (1976), United States v. Collyer Insulated Wire Co., 94 F. Supp. 493 (D.R.I. 1950), and this is true although many such claims may be submitted to the Government at one time. For example, a doctor who completes separate Medicare claims for each patient treated will be liable for a forfeiture for each such form that contains false entries even though several such forms may be submitted to the fiscal intermediary at one time. Likewise, each and every claim submitted under a contract, loan guarantee, or other agreement which was originally obtained by means of false statements or other corrupt or fraudulent conduct, or in violation of any statute or applicable regulation, constitutes a false claim. For example, all claims submitted under a contract obtained through collusive bidding are false and actionable under the act-Murray & Sorenson.

[page 10]

[5275] Inc. v. United States, 207 F.2d 119 (Ist Cit. 1953); United States ex rel. Marcus v. Hess, 317 U.S. 537 (1943)-as are all Medicare claims submitted by or on behalf of a physician who is ineligible to participate in the program. Peterson v. Weinberger, supra.

A claim upon any Government agency or instrumentality, quasi-governmental corporation, or

nonappropriated fund activity is a claim upon the United States under the act. In addition, a false claim is actionable although the claims or false statements were made to a party other than the Government, if the payment thereon would ultimately result in a loss to the United States. United States v. Lagerbusch, 361 F.2d 449 (3rd Cir. 19666); Murray & Sorenson, Inc. v. United States, 207 F.2d 119 (1st Cir. 1953). For example, a false claim to the recipient of a grant from the United States or to a State under a program financed in part by the United States, is a false claim to the United States. See, for example, United States ex rel. Marcus v. Hess, 317 U.S. 537 (1943); United States ex rel. Davis v. Long's Drugs, 411 F. Supp. 1114 (S.D. Cal. 1976).

The original False Claims Act also contained a provision allowing private persons, or "relators", to bring suit under the act. After providing for general subject matter jurisdiction and venue for all actions brought under the act, the statute provided that a suit "may be brought and carried on by any person, as well for himself as for the United States." The 1863 law, R.S. 3492, provided that:

the (action) shall be at the sole cost and charge of such person, and shall be in the name of the United States, but shall not be withdrawn or discontinued without the consent, in writing, of the judge of the court and the district attorney, first filed in the case, setting forth their reasons for such consent.

The original statute also provided that the private relator who prosecuted the case to final judgment would be entitled to one half of the damages and

forfeitures recovered and collected. If successful, the relator would also be entitled to an award of his costs.

Therefore, under the provisions of the original act, suits to redress fraud against the Government could be instituted as easily by a private individual, as by the Government's representative. Moreover, once the action was commenced by the relator, no one could interfere with its prosecution. The act contained no provision for the Government to take over the action and, in fact, the relator's interest in the action was viewed, at least in one instance, as a property right which could not be divested by the United States if it attempted to settle the dispute with the defendant. United States v. Griswold, 30 Fed. Rep. 762 (Cir. Ct., D. Ore. 1887).

In the early 1940s, several qui tam actions were brought regarding World War 11 defense procurement fraud. Some suits brought by private citizens appeared to be based on criminal indictments brought by the Government. In one such suit, United States ex rel Marcus v. Hess, 317 U.S. 537 (1943), the Government contended that an action brought by an informer who based his civil action on a criminal indictment should be barred under the provisions of the False Claims Act because he brought no information of his own to the suit, thereby thwarting the spirit of the act. The Government also contended that such suits created a race to the courthouse be-

[page 11]

[5276] tween the Government's civil lawyers and private parties, and infringed upon the Attorney

General's control over criminal and civil fraud actions. The Court rejected the Government's contentions and ruled that the statute, as then written, did not require the relator to bring original information to the suit or that the Attorney General should have exclusive control over the Government's civil fraud litigation. Writing for the Court, Justice Black stated that qui tam suits have been "frequently permitted by legislative action and have not been without defense by the courts." Id. at 541.

Justice Black also referred to an earlier decision, United States v. Griswold, 24 F. 361, 366 (D. Ore. 1885) in which the Court said:

The statute is a remedial one. It is intended to protect the Treasury against the hungry and unscrupulous host that encompasses it on every side, and should be construed accordingly. It was passed upon the theory, based on experience as old as modern civilization, that one of the least expensive and most effective means of preventing frauds on the Treasury is to make the perpetrators of them liable to actions by private persons acting, if you please, under the strong stimulus of personal ill will or the hope of gain. Prosecutions conducted by such means compare with the ordinary methods as the enterprising privateer does to the slow-going public vessel.

The factual issue of whether the private relator in Marcus v. Hess had actually performed an independent investigation or merely copied a criminal indictment in order to bring his suit, was never reached by the Court. The Court did find that:

Even if * * * the petitioner has contributed nothing to the discovery of this crime, he has contributed much to accomplishing one of the purposes for which the Act was passed. The suit results in a net recovery to the government of $150,000, three times as much as fines imposed in the criminal proceedings. Id. at 545.

The Marvus v. Hess decision prompted then Attorney General Francis Riddle to request that Congress repeal the qui tam provisions of the act. The House of Representatives passed repeal legislation,but the Senate passed an amendment to the House bill providingfor the retention of qui tam suits, with restrictions. The Senate debated at length regarding the advisability of leaving all Government fraud cases solely in the hands of the Attorney General. Senator Langer of North Dakota vehemently objected to any amendments to the qui tam law, citing Government delay in fraud cases and resource constraints for adequate enforcement. Langer argued:

I submit that the present statute now on the books is a most desirable one. What harm can there be if 10,000 lawyers in America are assisting the Attorney General of the United States in digging up war frauds? In any case, the Attorney General can protect himself by filing a (civil) lawsuit at the time when he files the indictment. 89 Cong. Rec. 7607 (Sept. 17, 1943).

[page 12]

[52771 The Senate specifically provided that jurisdiction would be barred on qui tam suits based on information in the possession of the Government unless the relator was the original source o£ that information.

Without explanation, the resulting conference report dropped the clause regarding original sources of allegations and courts have since adopted a strict interpretation of the jurisdictional bar as precluding any qui tam suit based on information in the Government's possession, despite the source. That jurisdictional bar, however, has been applied only to private qui tam suits, and not those suits taken over by the Government. United States v. Pittman, 151 F.2d 851 (5th Cir. 1946).

Despite considerable judicial adherence to the plain language of the jurisdictional bar in the statute, it is unclear whether Congress fully understood the clause that had been fashioned through the conference committee compromise. Senator Van Nuys who was chairman of the Senate Judiciary Committee which proposed the Senate amendments and who also served on the conference committee, stated in floor debate that the proposal "protects the honest informer as nearly we can do it by statute (and) * * * would not prevent an honest informer from coming in." 89 Cong. Rec. 7609 (1943). Similarly, Representative William Kefauver in summarizing the final proposal on the House floor stated, "(If) the average, good American citizen * * * has the information and he gives it to the Government, and the Government does not proceed in due course, provision is made here where he can get some compensation." 89 Cong. Rec. 10846 (1943).

The conference committee bill went on to provide that in the event the Government took over an action brought by a relator, the Court could award, out of the proceeds collected, fair and reasonable compensation, not to exceed 10 percent of the proceeds, to the relator

for his disclosure of information and evidence not in the possession of the United States when the suit was brought. In suits not carried on by the United States, the court could award the person who brought the action and prosecuted it up to 25 percent of the proceeds.

The conference report was accepted by both Houses of Congress without amendment, and signed by President Roosevelt on Dec. 21, 1941 The provisions of the statute were codified at 31 U.S.C. 232 which has recently been recodified along with the entirety of the False Claims Act at 31 U.S.C. 3729-3731.

The jurisdictional bar prohibiting suits based on information in the possession of the Government has been invoked several times over the past four decades.

Once a qui tam litigant has been found an improper relator due to this jurisdictional bar, he is no longer a part of the litigation and is precluded not only from receiving a portion of the proceeds, but also forfeits any rights to challenge the Government's "reasonable diligence" or object to settlements and dismissals. Courts have also found the jurisdictional bar to apply even if the Government makes no effort to investigate or take action after the original allegations were received, United States ex rel Lapin v. International Business Machines Corp., 490 F. Supp. 244 (D. Hi. 1980).

Additionally, in United States ex rel State of Wisconsin v. Dean, 729 F.2d 1100 (7th Cir. 1984), the Court refused to allow the State

[5278] of Wisconsin to act as a qui tam relator in a Medicaid fraud action even though the investigation had been conducted solely by the State of Wisconsin. The Court found that the Federal Government was in possession of the information due to the State disclosures of the fraud to the Department of Health and Human Services. The State was required to make such disclosures under Federal law governing Medicare programs. Interestingly, the Federal Government in this case not only declined to intervene and take over the suit, but filed a brief with the Court indicating its belief that Wisconsin was a proper relator. In rejecting the views of both the Federal Government and the State of Wisconsin, the Court noted that:

If the State of Wisconsin desires a special exemption to the False Claims Act because of its requirement to report Medicaid fraud to the federal government, then it should ask Congress to provide the exemption. Id. at 1106.

The National Association of Attorneys General adopted a resolution in June of 1984 stating that "to prohibit sovereign states from becoming qui tam plaintiffs because the U.S. Government was in possession of information provided to it by the State and declines to intercede in the State's lawsuit, unnecessarily inhibits the detection and prosecution of fraud on the Government." The resolution goes on to strongly urge that Congress amend the False Claims Act to rectify the unfortunate result of the Wisconsin v. Dean decision.

III. HISTORY OF S. 1562

The False Claims Reform Act, S. 1562, which was introduced on August 1, 1985 by Senators Charles E. Grassley (R, la.), Dennis DeConcini (D, Az.), and Carl Levin (D, Mich.), contains in large part amendments to the False Claims Act first proposed by the U.S. Department of Justice in 1979 and once again in the Department's Anti-Fraud Enforcement Package announced by Attorney General Edwin Meese III in September o£ 1985. As reported by the Committee, S. 1562 amends the civil False Claims Act, 31 U.S.C. 3729 and 3730, to increase forfeiture and damages for those found liable by a "preponderance of the evidence". The standard for liability is clarified as one who "knows or has reason to know" that the claim submitted to the Government is false. The bill also allows a qui tam, or private citizen relator, increased involvement in suits brought by the relator but litigated by the Government. Additionally, the relator could receive up to 30 percent of any judgment arising from his suit and is afforded protection from retaliation for his actions. Senator DeConcini bad sponsored a related measure, S. 1981, in the 96th Congress. While that legislation was reported favorably by the Senate Judiciary Committee in 1980, it failed to receive consideration by the full Senate before the adjournment of the 96th Congress. Evidence of rampant fraud in Government programs since that time has renewed the effort to legislate a more effective statute.

On September 17, 1985, the Senate Judiciary Committee's Subcommittee on Administrative Practice and Procedure held a bearing on S. 1562 and S. 1673, a similar bill proposed by the administration. Testifying

at that bearing were Jay Stephens, Associate

[page 14]

[5279] Deputy Attorney General, Department of Justice accompanied by Stuart E. Schiffer, Deputy Assistant Attorney General for the Civil Division, Department of Justice; John R. Phillips, Co-Director, Center for Law in the Public Interest; D. Wayne Silby, Business Executives for National Security; and three individuals, Mr. John Michael Gravitt; Mr. James B. Helmer, Jr.; and, Mr. Robert Wityczak.

All of these witnesses expressed strong support for amendments to the False Claims Act. Mr. John Phillips, testifying on behalf of the Center for Law in the Public Interest, focused his remarks on the necessity for enhancing the qui ram provisions under the False Claims Act, saying that an effective vehicle for private individuals to disclose fraud is necessary both for meaningful fraud deterrence and for breaking the current "conspiracy of silence" among Government contractor employees.

Two individuals who had exposed mischarging at defense contractor plants also expressed support for the amendments contained in S. 1562. Mr. John Gravitt, who filed a qui tam false claims suit against General Electric, testified that the changes in S. 1562 were necessary to encourage workers directed to participate in fraudulent schemes to expose that wrongdoing. Mr. Robert Wityczak, a former Rockwell International employee who also exposed falsification of time cards, stated that the false claims reforms in S. 1562 are imperative "to encourage employees like myself who

know first-hand of fraudulent misconduct to step forward."

Mr. D. Wayne Silby, testifying on behalf of Business Executives for National Security, said the business association supports S. 1562 because the bill "is supportive of improved integrity in military contracting. The bill adds no new layers of bureaucracy, new regulations, or new Federal police powers. Instead, the bill takes the sensible approach of increasing penalties for wrongdoing, and rewarding those private individuals who take significant personal risks to bring such wrongdoing to light."

Mr. Jay Stephens, testifying for the Justice Department, stated that the Department was very supportive of False Claims Act reforms and would recommend the consideration of supplemental provisions included in the administration-proposed S. 1673. Additionally, Stephens expressed some concern regarding the broadness of the qui tam amendments contained in S. 1562, but added that the Justice Department was willing to work with the Committee on developing a "practical solution" for legislation giving "long overdue weapons to deal with the problem of fraud."

In response to Justice Department concerns, S. 1562, and specifically the qui tam provision, was significantly revised at the subcommittee level and a substitute bill was reported favorably to the full Judiciary Committee on November 7, 1985. The S. 1562 substitute contained several provisions adopted from S. 1673.

First, the original constructive knowledge standard

defined as "acting in reckless disregard of the truth" was changed to the S. 1673 definition of "reason to know that the claim or statement was false or fictitious." While the two definitions are very similar, the Justice Department suggested that the definition from S. 1673 provided greater clarity and was better crafted to address the problem

[page 15]

[5280] of the "ostrich-like" refusal to learn of information which an individual, in the exercise of prudent judgment, had reason to know.

Second, the subcommittee adopted a provision allowing the full litigation of False Claims Act counterclaims asserted against an offender who initiates a case in U.S. Claims Court.

Third, the subcommittee added a provision permitting the United States to bring an action against a member of the armed forces, as well as civilian employees. The military has been excluded from False Claims Act liability since 1863 when the Government had available more severe military remedies. The subcommittee agreed, however, that military code remedies are inadequate to ensure full recoveries for fraudulent acts by servicepersons and such persons should therefore not be exempt from False Claims Act coverage.

Fourth, the subcommittee added a clarification that an individual who makes a material misrepresentation to avoid paying money owed the Government should be equally liable under the Act as if he had submitted a false claim. The Justice Department testified that

recent court rulings had produced an ambiguity as to whether such "reverse false claims" were covered by the False Claims Act, and the subcommittee agreed that such matters should be addressable under the Act.

Fifth, the subcommittee added a new uniform remedy to permit the Government to seek preliminary injunctive relief to bar a defendant from transferring or dissipating assets pending the completion of a false claims action. Currently, the Government's prejudgment attachment remedies are governed by State law and the subcommittee agreed that a uniform Federal standard would significantly enhance the Government's remedies as well as avoid inconsistent results.

Sixth, the subcommittee adopted a provision allowing the Federal Government to sue under the False Claims Act to prosecute frauds perpetrated on certain grantees, States and other recipients of Federal financial assistance. A recent decision, United States v. Azzarelli Construction Co., 647 F.2d 757 (7th Cit. 1981), created some confusion with respect to whether the federal Government may recover in grant cases where the Federal contribution is a fixed sum. The subcommittee agreed with the Justice Department's recommendation that it be made clear the United States may bring an action whether the grant obligation is open-ended or fixed.

Seventh, the subcommittee added a modification of the statute of limitations to permit the Government to bring an action within 6 years of when the false claim is submitted (current standard) or within 3 years of when the Government learned of a violation, whichever is

later. The subcommittee agreed that because fraud is, by nature, deceptive, such tolling of the statute of limitations is necessary to ensure the Government's rights are not lost through a wrongdoer's successful deception.

Eighth, the subcommittee adopted a provision granting Civil Investigative Demand, or CID, authority to the Justice Department Civil Division to aid in the investigation of False Claims Act cases. The subcommittee noted that the CID authority from S. 1673 is nearly identical to that available to the Antitrust Division under the Hart-Scott-Rodino Act of 1976, 15 U.S.C. 1311-1314. The sub

[page 16]

[5281] committee agreed with the Justice Department suggestion t0 add this carefully crafted investigative tool in an effort to produce more efficient and complete Government investigations.

Finally, the subcommittee agreed to several changes in the qui tam provisions of S. 1562.

First, in response to Justice Department concerns that qui tam complaints filed in open court might tip off targets of ongoing criminal investigations, the subcommittee adopted a 60-day seal provision for all qui tam complaints.

Second, the Justice Department expressed concerns that the broadening of qui tam provisions under S. 1562 might provoke a greater number of frivolous suits and specifically a greater number of actions filed merely for

political purposes. The subcommittee agreed to an amendment which limits the application of qui tam suits against political officials to only those cases involving information not already in the government's possession. As a further prevention of frivolous actions, the subcommittee adopted attorneys fees sanctions to be charged against any qui tam plaintiff who brings a clearly frivolous or vexatious suit. Additionally, the subcommittee amendment specifically provides that where an action appears to be brought in bad faith the court may halt the litigation pending assurances that the qui tam plaintiff can make payment of any legal fees and expenses the court may award.

Also in response to Department of Justice concerns that three levels of qui tam award portions would provoke additional litigation, the subcommittee adopted a simplified two-tier approach allowing 10-20 percent awards if the Government takes over the action and 20-30 percent if the qui tam plaintiff proceeds alone. In addition, so as to prevent any "windfalls" for persons who may not have had direct involvement with investigating or exposing alleged false claims that are the basis of a qui tam suit, in the very limited area where the qui tam action is brought at least 6 months after a public disclosure, the Government has failed to act, and the suit succeeds, the individual who brought the action would only receive "up to 10 percent" depending on his role in advancing the case to litigation.

The subcommittee substitute also added a provision authorizing the Attorney General to grant awards to informants who contribute to successful false claims suits. And finally, in response to comments from the

National Association of Attorneys General, the subcommittee adopted a provison allowing State and local governments to join State law actions with False Claims Act actions brought in Federal district court if such actions grow out of the same transaction or occurrence.

On November 7, the Subcommittee on Administrative Practice and Procedure met and voted to report favorably to the full Senate Judiciary Committee S. 1562 as amended by a subcommittee substitute offered by Chairman Grassley. The subcommittee voted 4 to 0 to report S. 1562 with Chairman Grassley and Senators Heflin, Specter and East voting in favor of the bill.

While the original S. 1562, as well as the subcommittee substitute, contained amendments to Rule 6(e) of the Federal Rules of Criminal Procedure regarding access to grand jury information, Chairman Grassley announced at the November 7 mark-up that

[page 17]

[52821 the full Senate Judiciary Committee would be addressing that issue separately and that Rule 6(e) amendments would be removed from S. 1562. On December 14, 1985, the full Senate Judiciary Committee voted by unanimous consent to favorably report S. 1562 to the Senate floor with the following amendments which came in response to suggestions offered by other Committee members and then offered by Senator Grassley:

First, as already noted, grand jury access amendments were removed.

Second, language was added to further define the constructive knowledge definition so that it paralleled that found in S. 1134, the Program Fraud and Civil Penalties Act as reported favorably from the Governmental Affairs Committee. While the standards were already very similar, S. 1134 contained further clarifying language and the Committee thought it unwise to allow the possibility of confusion and the lack of a uniformly applied standard in administrative and judicial civil false claims actions.

Third, the Committee adopted new language under the whistle-blower protection provision to ensure that remedies afforded under the act will not be abused by employees acting in bad faith or who ate discharged, demoted, etc. for legitimate reasons unrelated to any whistleblowing activity.

And finally, the CID authority was amended to require that other agencies seeking access to information obtained through CIDs must demonstrate to the appropriate Federal district court that they have a "substantial need" for the information rather than allowing the Justice Department alone to determine outside agency access.

IV. SECTION-BY-SECTION ANALYSIS

SECTION I

Section 1 of the bill amends section 3729 of title 31, United States Code, in several respects. . .

31 U.S.C. 3729, SUBSECTION (c)

New subsection (c) of section 3729 clarifies the standard of intent for a finding of liability under the act. This language establishes liability for those "who know, or have reason to know" that a claim is false. In order to avoid varying interpretations, the Committee further defined the standard as making liable those who have "actual knowledge that the claim is false, fictitious, or fraudulent, or acts in gross negligence of the duty to make such inquiry as would be reasonable and prudent to conduct under the circumstances to ascertain the true and accurate basis of the claim."

While it is clear that actual knowledge of a claim's falsity will confer liability, courts have split on defining what type of "constructive knowledge", if any, is rightfully culpable. In fashioning the appropriate standard of knowledge for liability under the civil False Claims Act, S. 1562 adopts the concept that individuals and contractors receiving public funds have some duty to make a limited inquiry so as to be reasonably certain they are entitled to the money they seek. A rigid definition of that "duty", however, would ignore the wide variance of circumstances under which the Government funds its programs and the correlating variance in sophistication of program recipients. Consequently, S. 1562 defines this obligation as "to make such inquiry as would be reasonable and prudent to conduct under the circumstances to ascertain the true and accurate basis of the claim." Only those who act in "gross negligence" of this duty will be found liable under the False Claims Act.

The standard in S. 1562 is identical to that in S. 1134, the Program Fraud and Civil Remedies Act which was reported favorably by the Senate Governmental Affairs

Committee in November of 1985 and is probably indistinguishable from the knowledge stand-

[page 21]

[5286] and found in H.R. 4560, reported favorably from the House Judiciary Subcommittee on Administrative Law and Governmental Relations in May of 1986. The Committee believes that the definition of knowledge under the False Claims Act should not differ from the definition of knowledge for any administrative adjudications regarding false claims. In both bills, the constructive knowledge definition attempts to reach what has become known as the "ostrich" type situation where an individual has "buried his head in the sand" and failed to make simple inquiries which would alert him that false claims are being submitted. While the Committee intends that at least some inquiry be made, the inquiry need only be "reasonable and prudent under the circumstances", which clearly recognizes a limited duty to inquire as opposed to a burdensome obligation. The phrase strikes a balance which was accurately described by the Department of Justice as "designed to assure the skeptical both that mere negligence could not be punished by an overzealous agency and that artful defense counsel could not urge that the statute actually require some form of intent as an essential ingredient of proof."

FOOTNOTES

* U.S.C.C.A.N. did not reprint Section IX of this report containing the actual bill. Accordingly. parallel citation to U.S.C.C.A.N. ends at 5303.

[1] GAO Report to Congress- "Fraud in Government Programs: How Extensive is it? How Can it be Controacd?", 1981.

[2] See Id. at 8-15.

[3] Hearings on Federal Securities Laws and Defense Contracting before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, House of Representa-tives, 99th Congress, 1st session (1985).

[4] Hearings on White Collar Crime before the Senate Committee on the Judiciary, 99th Congress, 2d session (1985).

[5] GAO Report, at 1.

[6] Hearings on the Departments of State, Justice and Commerce before the Subcommittee on the Departments of State, Justice and Commerce, the Judiciary and Related Agencies of the House Committee on Appropriations, 96th Congress, 2d session (1980).

[7] Hearings on Federal Securities Laws and Defense Contracting before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, House of Representatives, 99th Congress, 1st session (1985).

[8] GAO Report, at 19.

[9] GAO Report, at cover.

[10] Department of Justice Civil Division records show 2,850 fraud referrals in fiscal year 1984 and just 21 complaints filed and 70 settlements or judgments. In fiscal year 1985. the Division received 2,734 fraud referrals, filed 36 complaints and obtained 54 settlements or judgments.

[11] Report of the Economic Crime Council to the Attorney General, "Investigation and Prosecution of Fraud in Defense Procurement and Health Care Benefits Programs", April 30, 1985.

[12] "Blowing the Whistle in the Federal Government", Report of the United States Merit Systems Protection Board, Oct. 1984.

[13] Hearing on S- 1562, the False Claims Reform Act, before the Subcommittee on Administrative Practice and Procedure of the Senate Committee on the Judiciary, 99th Congress, 1st session, September 17, 1985.

[14] Id. at 80.

[15] Id. at 81.

[16] Id. at 85.

[17] Id. at 82.

[18] Id. at 87.

[19] Id. at 39.

[20] Id. at 39.

[21] 463 U.S. 418, 77 L.Ed.2d 743.

[22] Id. at 34.

[23] Id. at 35.

[24] Hearings on Defense Procurement Fraud Law Enforcement before the Subcommittee on Administrative Practice and Procedure of the Senate Committee on the Judiciary. 99th Congress, 1st session (1985).

[25] Id. at 18.

[26] See United States Department of Justice Source Book of Criminal Justice Statistics, 1981 at 431.

[27] 98 S.Ct. 2018, 56 L.Ed.2d 611.

[28] 96 S.Ct. 523, 46 L.Ed2d 514.

[29] 96 S.Ct 523. 46 L.Ed.2d 514.

132 Cong. Rec. S11243 (Aug. 11, 1986) (Statement by Sen Grassley)

Mr. GRASSLEY. Mr. President, the False Claims Act is the Government's primary weapon against fraud, yet it is in need of substantial reform. A review of the current environment is sufficient proof that the Government needs help – lots of help – to adequately protect the Treasury against growing and increasingly sophisticated fraud.

We have spent a considerable amount of time in the Judiciary Subcommittee on Administrative Practice and Procedure examining different types of frauds which steal away much needed taxpayer funds. In the face of our current Federal debt crisis, it is more important than ever that we maintain an efficient, fair, and most of all, effective enforcement system to protect our Federal dollars from fraud and abuse.

No single piece of legislation can absolutely guarantee an efficient, fair, and effective enforcement system. We would be deluding ourselves to assume that security. However, to the extent we can strengthen weaknesses in the law which allow frauds to go undetected or unaddressed and fraudulently obtained funds uncollected – that is the type of legislative remedy we should enact without delay.

There is no question that the current state of affairs begs for reform. Fraud allegations are climbing at a steady rate while the Justice Department's own economic crime council last year termed the level of enforcement in defense procurement fraud inadequate.

No one knows, of course, exactly how much public money is lost to fraud. Estimates range from hundreds of millions of dollars to more than $50 billion per year. Sadly, only a fraction of the fraud is reported and an even smaller fraction of the funds recovered.

Part of the solution – something I consider essential to any meaningful improvements in cutting down fraud – is the establishment of a solid partnership between public law enforcers and private taxpayers. The Federal Government has a big job on its hands as it attempts to ensure the integrity of the nearly $1 trillion we spend each year on various programs and procurement. That job is simply too big if Government officials are working alone.

The concept of private citizen assistance is embodied in S. 1562, the False Claims Reform Act which was unanimously approved by the Senate Judiciary Committee last December.

This bill, which I sponsored along with bipartisan cosponsors including my colleagues Senators DeConcini, Levin, Hatch, Cohen, and Metzenbaum, is strongly supported by the administration and its amendments have received endorsements from both the Packard Commission and the Grace Commission's committee against Government waste.

S. 1562 will enhance the Government's litigative and investigative tools under the False Claims Act, as well as increase the fines and penalties assessed against those who cheat the Government.

I have worked together with my colleagues Senators Hatch, Thurmond, and Hawkins, as well as others, to arrive at a consensus on S. 1562, the False Claims Reform Act. This final language addresses various concerns raised by those Members as well as a broad-based business coalition led by the chamber of commerce and including the Aerospace Industries Association, the Electronic Industries Association, and the Professional Services Council. I am pleased that this group has produced a comprehensive antifraud bill that will enhance both the effectiveness and the fairness of our fraud law enforcement effort.

I would like to take this opportunity to thank my colleagues who have worked with me to produce this very important and comprehensive legislation. I would especially like to thank Senator Hatch as well as Senator Hawkins for working in a cooperative manner to resolve the concerns that they raised.

The agreed-upon amendments which are incorporated in the committee modification are as follows:

KNOWLEDGE STANDARD

While throughout consideration of this bill there has been general agreement that liability should attach to one who "knows or has reason to know" of the falsity of his claim, debate has focused on the specific standard to be used to define "reason to know" or constructive knowledge.

The fundamental issue in designing a standard of knowledge is to reach not only defendants with actual knowledge of a false claim, but also defendants who

insulate themselves from that knowledge which a prudent person should have before submitting a claim to the Government, It is this problem of defining constructive knowledge, or of dealing with the "ostrich" – the individual who ignores or fails to inquire about readily discoverable facts which would alert him that fraudulent claims are being submitted – that has led to various formulations of the standard of knowledge.

S. 1562 as considered by the Subcommittee on Administrative Practice and Procedure, contained a "reckless disregard" standard which the sponsors as well as the Department of Justice believed would cover those persons who insulate themselves by design from knowledge about the truth of falsity of a claim. The concern was raised, however, that some case law exists in which reckless disregard is construed as requiring an intentional, deliberate, or willful act – a considerable escalation of the scienter requirement. To avoid the risk of such a misconstruction, the full Judiciary Committee then adopted a "gross negligence" standard which would appear to be less susceptible to this misinterpretation. The committee was aware that the two standards are very similar and in fact are often used to define each other; that is, reckless disregard often is defined as gross negligence and gross negligence frequently is said to require a reckless disregard.

While the committee expressed in its report accompanying S.1562 that mistake, inadvertence or mere negligence in the submission of a false claim would not be actionable under the bill, concerns, stemming mainly from the Government contracting community, were raised that such examples of mere

negligence might be construed as grossly negligent acts.

To address those concerns, I, along with the other sponsors of this bill, have agreed to return to a "reckless disregard" standard, but only with the express qualification that "no proof of specific intent is required." Our intent in returning to the reckless disregard standard is only to assure that mere negligence, mistake, and inadvertence are not actionable under the False Claims Act. In doing so, we reconfirm our belief that reckless disregard and gross negligence define essentially the same conduct and that under this act, reckless disregard does not require any proof of an intentional, deliberate, or willful act.

The constructive knowledge standard proposed by some has required a "conscious culpability." See, testimony of representatives of the Aerospace Industrial Association before the Committee on Government Affairs, Hearing on Program Fraud Civil Penalties Act of 1985, Senate Hearing 99-202, page 106. Under this formulation, "no duty to ascertain facts" may be imposed unless "deduced as inferences from facts already known." Id., page 119. Such conceptualizations of the standard exceed the committee's intent and leave unaddressed the "ostrich" problem which it is in agreement must be included.

QUI TAM

Several minor changes will be made in the qui tam section of S. 1562. Specifically, jurisdiction for qui tam actions based on information that has been publicly disclosed will be limited to those people who were

"original sources" of the information. "Original source" is further defined as "an individual who has direct and independent knowledge of information on which the allegations are based and has voluntarily informed the Government or the news media prior to an action filed by the Government."

This amendment seeks to assure that a qui tam action based solely on public disclosures cannot be brought by an individual with no direct or independent knowledge of the information or who had not been an original source to the entity that disclosed the allegations.
In the definition of "original source," the requirement that the individual "voluntarily" informed the Government or news media is meant to preclude the ability of an individual to sue under the qui tam section of the False Claims Act when his suit is based solely on public information and the individual was a source of the allegations only because the individual was subpenaed to come forward. However, those persons who have been contacted or questioned by the Government or the news media and cooperated by providing information which later led to a public disclosure would be considered to have "voluntarily" informed the Government or media and therefore considered eligible qui tam relators.

The use of the term "Government" in the definition of original source is meant to include any Government source of disclosures cited in subsection (5)(A); that is, Government includes Congress, the General Accounting Office, any executive or independent agency as well as all other governmental bodies that may have publicly disclosed the allegations.

The amendments also limit the possible portion of the judgment recoverable by a qui tam plaintiff to 10 percent or less when the action is based primarily on public information. This limitation will affect those persons who have brought a qui tam action based almost entirely on information of which they did not have independent knowledge but had derived from a public source.

The bill as reported by the Judiciary Committee contains a provision for the award of attorneys fees to prevailing defendants if the court finds that the plaintiff's action was clearly frivolous, vexatious, or brought for purposes of harassment. Additionally, the bill provides that the court at any time, may make certain assurances the plaintiff will be able to pay such costs if it appeares an action is being brought in bad faith or is clearly frivolous.

The committee amendment makes consistent the standards for both attorney's fees sanctions and the court-required assurances. While the standards are meant to be consistent, concern was raised that a court would find it impossible to rule any action "appeared" "clearly frivolous." Because the court could be making a judgment of apparent frivolity at an earlier stage of the case, as opposed to concluding the action's frivolity at the end of the proceedings, the conclusive term "clearly" was removed.

These amendments also make clear that no jurisdiction will lie for qui tam actions based on allegations upon which the Government has already initiated administrative civil money penalty proceedings.

CONSEQUENTIAL DAMAGES

The committee amendment limits consequential damages to those that are reasonably foreseeable to the defendant at the time the alleged fraud was committed or at the time of the submission of the claim or statement.

CIVIL INVESTIGATIVE DEMANDS

The committee amendment requires that only the Attorney General can authorize issuance of a Civil Investigative Demand. Second, these amendments make clear that prior to issuing a Civil Investigative Demand, the Justice Department must make reasonable efforts to obtain the same information through other, less burdensome sources. These other sources would include the material already in the possession of the agency investigative office which has made the referral of the fraud case as well as information which the Department could obtain through an informal request to the person who might otherwise be the target of the Civil Investigative Demand.

However, this amendment would not require the Department to seek a court order for access to grand jury material – under rule 6(e) of the Federal Rules of Criminal Procedure – in cases where such information might be available. Some circuits interpreting rule 6(e) have concluded that the Department should use other investigative techniques, including CID's, before seeking a 6(e) order. See, IN RE GRAND JURY INVESTIGATION, 774 F.2d 34 (2d Cir. 1985, cert. granted. This amendment would mirror the trend in

that caselaw, by authorizing the Justice Department to issue a CID without requiring it to first attempt to obtain a 6(e) order.

In addition, this amendment would not require the Justice Department to justify why it had not prevailed upon agency investigators to utilize their subpoena powers, either under the Inspector General Act of 1978 or any investigative powers associated with any civil money penalty authority.

Finally, these amendments should not be construed to allow the recipient of a CID to argue that the Justice Department should be required to file suit and use ordinary civil discovery. The term "not otherwise reasonably available" refers to presuit investigative techniques only.

STATUTE OF LIMITATIONS

The committee has added a tolling provisions to the False Claims Act which is adopted directly from 28 U.S.C.2416(c). While section 2416(c) is a provision of general applicability, the committee intends that the False Claims Act tolling provision be liberally construed because the conduct addressed here is so inherently deceptive and carefully concealed. Thus, courts should be leary of finding that the Government had knowledge of the existence of a possible cause of action based merely upon the discovery of irregularities that fall short of a concrete suspicion that fraud has occurred. Some corroborative information to support that suspicion should be required. Similarly, care should be taken to assure that the information has reached an official in a position both to recognize the

existence of a possible violation of this act and to take steps to address it.

SELF-POLICING INCENTIVE

The amendments add a provision intended to provide incentive for self-policing among those who conduct business with the Government. Under this new provision, the court in its discretion may limit damages to an amount between double and treble and the civil forfeiture between $5,000 and $10,000 if the defendant satisfies certain criteria. Given the deceitful nature of fraud, courts should construe narrowly the requirements defendants must satisfy in order to be eligible for liability limitations. Particularly, courts should guard against defendants attempting to take advantage of this provision once they realize Government or public discovery of violations are impending.

SMALL BUSINESS FINE LIMITATION

Under the committee amendment, defendant businesses or organizations meeting a certain size standard may be eligible for a reduction in fines if the court finds assessment of a $10,000 fine to that particular defendant would result in substantial hardship for the defendant.

The applicable size standard – gross annual receipts of $1 million or less and 800 employees or less – is adapted from statistics compiled by the National Federation of Independent Businesses. Based on its statistically representative sampling of the small business community, approximately 80 percent of such

businesses would fall within this size standard.

132 Cong. Rec. H6478-6479 (Sept. 9, 1986)
(Statement by Rep. Glickman)

Mr. GLICKMAN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is a very important bill, the False Claims Amendments Act, because it increases significantly the penalties for filing false claims against the Government of the United States; claims that could involve the Medicare system, claims to the Defense Department, the veterans' system, welfare; you name it. It deals with the issue of civil and criminal penalties for those who try to take advantage of taxpayers in this country by filing false claims against the Government.

This bill increases, rather substantially, the rights of citizens to challenge that and the penalties incurred thereby.

Before I begin my statement, I would like to especially thank those Members that have helped with this piece of legislation. They are Mr. Kindness, Mr. Fish, and Mr. Brown of Colorado from the Republican side, who has been so cooperative in helping with this area, as well as Mr. Brooks, Mr. Frank, Mr. Bryant, Mr. Stark, Mr. Bedell, and Mr. Ireland.

I also want to particularly give reference to Mr. Berman of Califonria because it was largely through his efforts on the citizens' suit or the qui tam provisions that we were able to work this deal together. Again, to our colleague from Texas, Mr. Brooks, for his help as well.

Mr. Speaker, in 1863, during the Civil War, the False Claims Act became law. This act, sometimes referred to as the "Abraham Lincoln Law", was enacted amid reports of widespread corruption and fraud in the sale of supplies and provisions to the union government during the war. As originally enacted, the statute imposed civil and criminal liability for false claims against the Government.

Unfortunatly, fraud against the U.S. Government did not end with the conclusion of the Civil War in 1865. However, the act has only been amended twice in 123 years: Amendments to the qui tam provisions were enacted in 1943, and in 1982, technical amendments were made during the recodification of title 31, where the civil false claims provisions are set forth in the United States Code. With this brief background of the False Claims Act, it is easy to understand why the current law is quite outdated. During hearings before the Subcommittee on Administrative Law and Governmental Relations, several witnesses pointed out that a large part of the problem in prosecuting civil fraud cases is because of the ambiguities and lack of clarity in the current statute, and also because the monetary penalties are no longer a serious deterrent to the filing of false claims.

H.R. 4827, the False Claims Amendments Act of 1986, is a very important piece of legislation. The False Claims Act is the primary vehicle by which the Government prosecutes civil fraud. In 1986, with a deficit in the range of $200 billion, I think it is critically important that we modernize this statute so that the Government has a workable law through which to prosecute fraud and recoup the losses suffered by the

Government.

One of the major provisions of H.R. 4827 increases the amount of damages recoverable to not less than $5,000 and not more than $10,000. The bill also provides for recovery of consequential damages. Under the current statute, the penalty is $2,000 and makes no provision for the recovery of consequential damages. As an example of how out of date this statute has become, the Congressional Research Service has informed me that the equivalent of $2,000 in 1863 would today be close to $18,000.

Other provisions of the bill include expanding the qui tam, or citizen suit, provisions of the law, as well as providing the Government with the power to issue civil investigative demands.

Civil investigative demands [CID's] are a pre-lawsuit discovery mechanism which allows the Department of Justice to conduct discovery in civil false claims cases, without the expense of first filing a civil fraud case in Federal district court. This CID provision, however, can only be utilized by the Department of Justice if the Attorney General himself approves the issuance of such.

The bill which we are considering today and which is at the desk, is not exactly like the bill which was reported by the full committee on June 10, 1986. Although H.R. 4827, as amended, was reported by the full committee by a unanimous (35-0) rollcall vote, several Members still had reservations about a few provisions contained in the bill. In order to satisfy these reservations, a compromise was reached which includes the following

changes to the bill:

First, there is a change to section 3, the qui tam provisions of the bill. In the bill as reported by the committee, the qui tam plaintiffs rights when the Government enters the lawsuit, were based on the rights of mandatory intervention, pursuant to rule 24(a) of the Federal rules of civil procedure. The bill at the desk adopts the standard of intervention to be that of permissive intervention pursuant to rule 24(b) of the Federal rules. The compromise bill also includes language which provides the qui tam plaintiff with the right to notice of any motion to dismiss filed by the Government and a right to a hearing on any such motion.

Second, the administrative remedy (section 7) was deleted in its entirety. The administrative remedy contained in the bill as reported by the committee applied government-wide and there were numerous concerns with this provision by several Members. Therefore, this provision has been deleted.

Third, in section 3 of the bill, the Contract Disputes Act language is deleted. With the deletion of the administrative remedy, this bill amends only the current False Claims Act. Since the False Claims Act and the Contract Disputes Act of 1978 have coexisted since 1978, it was decided as part of the compromise, to delete this portion of the bill.

As I said earlier, the False Claims Amendments Act of 1986 is a very important piece of legislation. It is important because it is the primary mechanism through which the Government recoups losses suffered through

fraud. It is especially important today given the enormous deficit the Government faces today. Perhaps, if the False Claims Act had been clarified and updated 30 years ago, we might not face quite the same deficit we do today. In any event, the modernization of this statute can and should enable the Government to recoup potentially thousands of dollars lost through fraud each year.

I would note for the record that the administration supports this bill, and, in addition, the Congressional Budget Office indicates that the bill would have a positive impact on our deficit.

Mr. Speaker, I urge my colleagues to support this legislation.

132 Cong. Rec. H6480 (Sept. 9, 1986) (Statement by Rep. Fish)

Mr. FISH. Mr. Speaker, I thank my colleague, the gentleman from Colorado [Mr. Brown].

Mr. Speaker, I rise in support of the False Claims Amendments Act of 1986. This legislation will greatly enhance the ability of the Federal Government to deal with fraud and waste in Government grant and loan programs and procurement contracts. As the principal sponsor of the administration's original proposals (H.R. 3334; H.R. 3335) on this subject, I believe that we have fashioned a workable, effective compromise and want to express my sincere appreciation to the administration, in particular the Department of Justice, for its expert assistance in this effort.

Mr. Speaker, the False Claims Act is one of the oldest and potentially most effective remedies available to the United States to discourage and respond to the fraudulent misuse of Federal resources. It is the principal statute upon which the Government relies to seek monetary recovery in fraud cases. The statute was first enacted in 1863, at the height of the Civil War. It permits the Federal Government to recover two times the amount of any false or fraudulent claim submitted, plus a $2,000 civil fine. Closely patterned after bills I originally introduced, the amendments contained in H.R. 4827 would make several statutory changes so as to resolve inconsistencies and ambiguities in current case law and strengthen the Government's ability to investigate, litigate, and otherwise resolve fraud cases.

It should be stressed, Mr. Speaker, that we are dealing here with a civil – not a criminal – statute. The False Claims Act is remedial in nature. The reason for my emphasis on this point is that considerable confusion has been prompted by judicial decisions that have treated the False Claims Act as if it were a criminal statute. These decisions have severely hampered the Justice Department and other Federal agencies in their efforts to effectively recover losses incurred as a result of fraud, waste, and abuse. These cases, in part, are the reason why I introduced the administration's package.

Second, while the False Claims Act is not a penal statute, it does have an important deterrent effect. The False Claims Act allows the Government, on behalf of the taxpayer, to recover losses suffered through the submission of fraudulent claims. The double damages remedy has been a part of this law since 1863 and it implicitly contains a significant deterrence element. The double damages recovery, with the accompanying civil fine, is intended to be a substantial penalty – to forcefully discourage individuals and companies that do business with the United States from engaging in fraudulent practices. Indeed, Mr. Speaker, the dual purpose of any such law should always be to deter as well as punish fraudulent conduct.

Under current law, the Federal Government is limited to actual damages, which are then doubled under the statutory formula. Section 2 of H.R. 4827 would make consequential damages the measurement standard – thus allowing a recovery for indirect losses that are the result of the fraud as well as actual, direct losses. This is a realistic, fair change which ensures the recovery will reflect actual replacement cost in every instance.

Last, but not least, I feel I must stress that I do not view these legislative proposals as anticontractor in nature. Rather, I view these legislative proposals as protaxpayer. There is no question in my mind but that the responsible representatives of the private sector share our common goals. Specifically, those goals are: First, an efficent Federal procurement process that results in the purchase of quality products and services at fair prices; and second, an effective mechanism for the Government to employ in recovering its losses when victimized by fraud.

Mr. Speaker, allow me to turn to those provisions in the bill that are deserving of special note. To my mind, one of the most important amendments contained in H.R. 4827 deals with the intent standard and the burden of proof in the False Claims Act. The language of the False Claims Act currently provides that the Federal Government need only prove that the defendant knowingly submitted a false claim. However, this statutory standard has been misconstrued by some courts so as to require that the Government prove the defendant had actual knowledge of the fraud and, even, establish specific intent to submit a false claim. See UNITED STATES v. MEAD, 426 F.2d 118 (9th Cir., 1970). A specific intent standard, Mr. Speaker, is inappropriate in a civil statute and H.R. 4827 would remove the ambiguity created by this case law by defining knowingly as: First, actual knowledge of the information; second, deliberate ignorance of the truth or falsity of the information; or third, acts in reckless discregard of the truth or falsity of the information.

The burden of proof in civil false claims cases is another area where legislative clarification is necessary to

resolve ambiguities which have developed in the case law. Some courts have required that the United States prove a violation by clear and convincing, even unequivocal, evidence. UNITED STATES v. UEBER, 299 F.2d 310 (6th Cir., 1962). Because the False Claims Act is a civil statute, the traditional "preponderance of the evidence" burden of proof is more appropriate. Consequently, H.R. 4827 specifically provides that the Government must prove its case by a preponderance of the evidence, the ordinary standard in civil litigation.

H.R. 4827 also contains numerous other amendments, which are designed to resolve specific problems which have arisen under the act:

Section 2(a) raises the fixed statutory penalty for submitting a false claim from $2,000 to not less than $5,000 and not more than $10,000. The $2,000 figure has remained unchanged since the initial enactment of the False Claims Act in 1863.

Section 2(a) also amends the act to permit the United States to bring an action against a member of the Armed Forces, as well as against civilian employees. When the act was first enacted in 1863, the military was excluded because the Government then had available more severe military remedies.

Also, as I mentioned earlier, section 2(a) would permit the Government to recover consequential damages it suffers from the submission of a false claim.

Section 2(a) also provides that an individual who makes a material misrepresentation to avoid paying money owed the Government would be equally liable under

the act as if he had submitted a false claim for money or property. This is better known as a reverse false claim. For instance, the manager of HUD-owned property may falsely understate income and/or overstate expenses in order to reduce the rental receipts which must be paid to HUD at the end of each month. The existing failure to cover these reverse false claims is a serious loophole in the present law. The requirement that there must be a strict demand for money or property before an actual claim can exist under the False Claim Act should be broadened. Instead, the concept of claim should cover all those circumstances where the Government suffers a real financial loss, through a fraudulent misrepresentation or statement.

Section 5 amends the statute of limitations to permit the Government to bring an action within 6 years of when the false claim is submitted, the current standard, or within 3 years after the Government learns of the violations, whichever is later.

Section 6 of the bill modernizes the jurisdiction and venue provisions of the False Claims Act to permit the Government to bring suit, not only in the district where the defendant is found, the current standard, but also where a violation occurred. Currently, when multiple defendants live in different districts, the Government may be required to bring multiple suits, a time-consuming process that is wasteful of judicial and litigation resources.

Another important amendment – contained in section 6 – is the grant of civil investigative demand [CID] authority to the Department of Justice to aid in the investigation of False Claims Act cases. The CID

provisions are patterned after and analogous to the authority already exercised by the Antitrust Division under the Hart-Scott-Rodino Act. 15 U.S.C. 1311-1314. If the Attorney General of the Civil Division believes that a person has access to information relating to a False Claims Act investigation, he may, prior to filing a complaint, require the production of documents, answers to interrogatories, and oral testimony. The standards governing subpoenas and ordinary civil discovery would apply so as to protect against the disclosure of privileged information. The CID could be enforced in district court, like any other subpoena. The use of CID authority in the antitrust context has been upheld as constitutional. HYSTER COMPANY v. UNITED STATES, 338 F.2d 183 (9th Cir., 1964); PETITION OF GOLD BOND STAMP CO., 221 F. Supp. 391 (D. Minn. 1963), aff'd., 325 F.2d 1018 (8th Cir., 1964).

In conclusion, Mr. Speaker, I want to commend subcommittee Chairman Dan Glickman, the ranking Republican Tom Kindness, and the other subcommittee members for their hard work in bringing this legislation to the floor. There is no question that Congress must seek out appropriate legislative mechanisms to insure that the taxpayers' money is well spent and protected from fraud and waste. This bill, Mr. Speaker, will accomplish just that.